

**MEMORANDUM OF
UNDERSTANDING**

Between

County of Del Norte

and

Del Norte County Sheriff's

Employees Association

November 2017



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ARTICLE I

TERM

This Memorandum of Understanding shall become effective November 1, 2017, and shall remain in full force and effect through October 31, 2019. The parties shall commence negotiations for a successor agreement no later than May 1, 2019.

This Memorandum of Understanding (MOU) is entered into by the County of Del Norte (hereinafter referred to as "County") and the Del Norte County Sheriffs Employees Association (hereinafter referred to as "SEA") under the authority of Government Code Section 3500 et seq.

RECOGNITION

The County of Del Norte recognizes and certifies Del Norte County Sheriffs Employees Association as the exclusive bargaining unit for employees under the authority of the Del Norte County Sheriff-Coroner other than management, mid-managers, Commanders or like positions and employees represented by another bargaining unit. See Attachment A for a list of positions covered by this Agreement.

MANAGEMENT RIGHTS AND RESPONSIBILITIES

The County retains, solely and exclusively, all the rights, powers and authority exercised or held prior to the execution of this Agreement, except as expressly limited by a specific provision of this Agreement. Without limiting the generality of the foregoing, the right, powers and authority retained solely and exclusively by County include, but are not limited to, the following: To manage and direct its business and human resources; to manage, control and determine the mission of its departments, building facilities and operations; to create, change, combine or abolish jobs, departments and facilities in whole or in part; to direct the work force; to increase or decrease the work force and determine the number of employees needed; to hire, transfer, promote, demote, layoff and maintain the discipline and efficiency of its employees; to establish work standards, schedules of operation and reasonable work load; to specify or assign work requirements and require overtime; to schedule work, working hours and shifts; to adopt rules of conduct; to determine the type and scope of work to be performed by County employees and the services to be provided; classify positions and determine the content and title of such classifications; to determine the methods, processes, means and places of providing services and to take whatever action necessary to prepare for and operate in an emergency.

Management Responsibilities

The exercise of these rights shall not preclude the SEA from meeting and conferring with the County on the impact of County actions on matters within the scope of representation pursuant to Government Code §3500 et seq. or otherwise limiting the exercise of particular rights in accordance with the express terms of this agreement.

Management is expected to conform to the standard of conduct expected of public employees and is expected to refrain from activity which is in violation of federal, state or county law, or the County Employer-Employee Relations Policy.

ARTICLE II DEFINITIONS

The following definitions shall be applied throughout this MOU and shall have the respective meanings given unless it is clearly apparent from the context that they are used in a different sense. The definition of a word shall apply to any of its variants:

- 2.1. **Anniversary Date:** The date of an employee's beginning performance of the duties of a given permanent position that an employee becomes eligible for an annual step increase under the provisions of this agreement. The anniversary date may change as an employee changes positions, is promoted, demoted, or on an unpaid leave of absence.
- 2.2. **Appointing Authority:** A unit or department head to whom authority is delegated to make the appointment to fill a vacant position and to remove employees from employment.
- 2.3. **Assignment:** A particular project, program and/or activity related to the function and needs of the department.
- 2.4. **Class Series:** A series of positions in a particular class that may consist of entry, journey and/or lead person levels (i.e.; I, II, III, etc.).
 - A. Entry level is typically a trainee level. The entry level is assigned duties that will increase experience. Employees perform the more routine, less complex job assignments, while learning the more complex operation, policies, assignments and programs related to their department or division function.
 - B. Journey level is the experienced working level. It is the second level in a class series and may be assigned paraprofessional, complex job assignments under minimal supervision. Employees advancing to this level in the series have demonstrated qualifications and the ability to adequately fulfill the assigned responsibilities.
 - C. Lead worker or skilled level is the most experienced characterized by a combination of high-level job assignments. Employees perform the full range of journey or specialist job assignment while also providing work direction, training and coordination for other workers. The emphasis of this series is on performing the more paraprofessional, complex work assignments. Employees advanced to this level are provided general direction in the performance of their responsibilities.
- 2.5. **Catastrophic Illness or Injury:** A severe illness or injury which is expected to incapacitate the employee for an extended period of time and which creates a financial hardship because the employee has exhausted all of his/her accumulated paid leave time. Catastrophic illness or injury is further defined as a debilitating illness or injury of an employee's spouse, son, or daughter that results in the employee being required to take time off from work for an extended period to care for the family member. An employee's job related illness or injury subject to workers' compensation coverage shall not be eligible for this catastrophic leave provision.
- 2.6. **Class:** A group of positions with the same title and alike in duties, responsibilities and authorities requiring the same qualifications and level of compensation (salary rate). Positions in this group are assigned to various programs and/or activities at the department head's discretion.
- 2.7. **Classification:** The process of job analysis and documentation by which newly-created positions are defined and delineated in a formal class description, and assigned a specific rate of pay.

- 2.8. **Compensatory Time Off (CTO):** Time off with pay to compensate an employee for overtime worked in lieu of cash compensation.
- 2.9. **Continuous Service:** Uninterrupted employment with the County from the effective date of employment, on a continuous paid status basis. A County approved paid leave of absence does not constitute interruption of employment.
- 2.10. **Demotion:** Movement of an employee from one position to another position having a lower maximum salary range.
- 2.11. **Department:** A distinct branch of County government that may consist of one or more units or divisions.
- 2.12. **Department Head:** A person who manages a department of County government and who reports directly to the Board of Supervisors.
- 2.13. **Disciplinary Action:** A negative action taken against an employee by the appointing authority in response to an employee's action, work performance, conduct, behavior, etc. that constitutes grounds for discipline.
- 2.14. **Discrimination:** As generally used in human resource laws, discrimination refers to the unlawful adverse treatment of an employee or groups of employees, whether intentional or unintentional, based on such characteristics as race, color, national origin, religion, sex, handicap or age.
- 2.15. **Dismissal:** Termination of employment with Del Norte County for reasons attributable to the employee for violation of standards of conduct; safety regulations; unsatisfactory performance or any combination thereof that constitute cause and grounds for dismissal.
- 2.16. **Division:** A functional unit of County government within a department.
- 2.17. **Division Manager:** A director, manager or supervisor of a division.
- 2.18. **Employee:** Any person who has been hired and occupying an authorized position in County service.
- A. **Confidential Employee:** An employee so designated by the Board of Supervisors who has access to privileged and confidential information relating to the County's administration of employer-employee relations and other human resource matters. Employee's access to these confidential matters shall be strictly limited to the areas of work in which they are normally engaged.
- B. **Extra Help Employee:** An employee who works to cover vacations, sick leave or other anticipated or unanticipated absences of a permanent full-time or part-time employee on a limited term basis. An extra help employee is limited to working less than 1,000 hours per fiscal year in a temporary, seasonal, on-call, part-time or other capacity. Extra help employees do not receive vacation, sick leave, holiday pay, health benefits, PERS benefits, longevity pay or other benefits, incentives and conditions of employment specifically provided to permanent full-time or permanent part-time except those mandated by law. Extra help employees do not have a probationary period or achieve permanent status.
- C. **Limited-Term Employee:** An employee who works in a program of a limited duration, duration to be specified at commencement of employment. Limited-term employees are paid per unit of work or on an hourly basis. Limited-term employees

shall not accrue holidays, vacation, and sick leave benefits or be entitled to group insurance or other types of benefits provided to permanent employees, nor shall they be covered by the provisions of this MOU.

- D. **Mid-Management/Professional Employee:** An employee classification designated by the Board of Supervisors engaging in specialized and responsible work requiring knowledge acquired by prolonged course(s) of specialized instruction or study and whose work may include management duties of a department, division or unit who carries out the departmental management policies.
 - E. **Permanent Employee:** An employee who is hired to perform the duties of a full-time or part-time position allocated to a County departmental staffing chart.
 - F. **Probationary Employee:** An employee serving in a permanent full-time or part-time position that has not completed the six-month or one-year probationary period for the position as required in this MOU.
 - G. **Provisional Employee:** An employee filling a permanent full-time or part-time position while awaiting certification from an eligibility list or completion of hiring procedures. Provisional employment must be approved by the Human Resources Manager. Under no circumstances will an employee be in a provisional status for more than ninety (90) days unless approved by the Board of Supervisors.
 - H. **Seasonal Employee:** An employee hired to perform duties associated with seasonal or recreational programs and/or activities.
 - I. **Temporary Employee:** An extra-help, limited term or seasonal employee hired for an established time period, usually during peak or seasonal workloads or for vacation or other extended absence relief. Temporary employees are paid on an hourly basis and are not eligible for benefits outlined in this MOU or the provisions therein.
 - J. **Work Experience Employee:** An employee participating in a job training program performing work in a position established to give temporary on-the-job training.
- 2.19. **Fair Labor Standards Act (FLSA):** A federal law enacted in 1938 and subsequently amended to include county government that governs minimum wage, overtime pay, equal pay, child labor standards and record keeping requirements. Not all employees of local government are affected by the FLSA. Certain positions are covered by the FLSA but exempted from specific provisions. Positions affected by the FLSA are designated as exempt, and non-exempt. An employee's status as exempt or non-exempt establishes whether that employee is subject to overtime under the Act. For purposes of this MOU the designations apply only to the overtime provisions.
- A. **Exempt Employee:** A term used to describe positions and employees who are not subject to the overtime provisions of the Fair Labor Standards Act.
 - B. **Non-Exempt:** A term used to describe positions and employees who are subject to the overtime provisions of the Fair Labor Standards Act.
- 2.20. **Family Medical Leave Act (FLMA):** The Family and Medical Leave Act of 1993 is a federal law that allows an individual up to 12 weeks leave based on medical necessity for self, child, spouse or parents. (See Personnel Rules Manual for details.)
- 2.21. **Grievance:** A grievance is a written complaint of an employee or group of employees alleging a violation, or misapplication of a provision of this Memorandum of Understanding, or adopted county policies, state or federal law or regulations.

- 2.22. **Grievant:** A grievant is an employee or groups of employees within the bargaining unit alleging a grievance.
- 2.23. **Immediate Family:** The lawful spouse or registered domestic partner, parent, or parent in-law, sibling, child, grandparent or grandchild of the employee. Step-children, step-siblings, step-parents, step-grandparents or step-grandchildren residing in the same household.
- 2.24. **Job Description:** The document that defines the general essential duties, responsibilities, required skills, training and education applicable to incumbents in a class or position. Department heads assign incumbents to various programs and/or activities according to the needs of the department.
- 2.25. **Layoff:** Termination of employment based upon policy decision of the Board of Supervisors.
- 2.26. **Leave of Absence:** Absence from duty on paid or unpaid basis under the provisions of Article V of this MOU.
- 2.27. **Longevity:** Ten or more years of permanent county service.
- 2.28. **Pay Period:** Biweekly pay period means the 2-week period for which an employee is scheduled to perform work beginning at 12:00am on Friday and concluding at 11:59 pm on the second following Thursday.
- 2.29. **Performance Improvement Plan:** A written plan devised by the appointing authority to rectify or improve substandard performance.
- 2.30. **Positions Eligible for Benefits:**
- A. **Emergency Position:** A position which is authorized by the Board of Supervisors during an emergency situation in order to prevent stoppage of public business, loss of life, or damage to persons or property. Entitlement to benefits will be determined by the Board of Supervisors on a case-by-case basis.
 - B. **Grant Position:** A position, typically, of limited duration created as a result of County participation in Federal or State programs. Employees shall be entitled to those benefits as required in the grant program. Should funding cease for the grant program or portions of the grant program, the affected position(s) shall be terminated.
 - C. **Permanent Full-Time Position:** A position approved and allocated on the County staffing chart by the Board of Supervisors, in which the employee works a continuing year-round shift of forty (40) or more hours per week or eighty (80) or more hours per work period.
 - D. **Permanent Part-Time Position:** A position approved and allocated on the County staffing chart by the Board of Supervisors to be permanent, in which the employee works year-round averaging fifteen (15) twenty to (20) hours or more per week. These employees are entitled to benefits provided permanent full-time employees under this MOU. Such benefits are prorated in proportion as the part-time employees regular weekly hours bear to full-time hours.
 - E. **Provisional Position:** A position created for evaluation of the position's effectiveness or a period of time as specified by the Board of Supervisors.
- 2.31. **Progressive Discipline:** An approach to imposing disciplinary action in which a lesser penalty may be appropriate for minor offense the first time and more severe penalties are imposed for repeating the same or other offense(s). Progressive discipline will be used when the Appointing

Authority believes that progressive discipline shall serve the dual purpose of providing both corrective warning and a penalty to an employee whom the appointing authority intends to retain as an employee after discipline. Discipline may be imposed at any level depending upon the severity of the charges. Progressive discipline shall not be required when the appointing authority believes dismissal to be the appropriate discipline because of the severity of the employee's conduct.

- 2.32. **Probationary Period:** A period regarded as part of the examination process, which provides the appointing authority an opportunity to observe and evaluate an employee's competence and ability to perform the assigned duties satisfactorily.
- 2.33. **Promotion:** The movement of an employee from a position in one class to a position in a class with a higher maximum salary rate, or an increase in rate of pay for an employee's current position as a result of a reclassification.
- 2.34. **Reclassification:** The process of job analysis and documentation by which positions are re-defined in response to changes in the duties, responsibilities and skills required of the incumbents. Reclassified positions may be assigned to different pay rates when justified by the degree of change. Reclassification does not affect an employee's anniversary date, unless reclassification results in a promotion.
- 2.35. **Regular Working/Business Day:** The appointing authority or their designee shall schedule employees work hours, consistent with the operational needs of the department. Not all employees within the department need work the same days or hours. The regular working/business week, shall consist of forty (40) hours during seven consecutive days including Friday through the following Thursday, excluding holidays, except for those positions designated as ten (10) and twelve (12) hour per day positions as provided in Article IV, Section 4.12.
- A. The Appointing Authority, or the employees' immediate supervisor, when authorized by the Appointing Authority, may authorize an employee or group of employees to work an altered work schedule/flexitime where the needs of the employee(s) make an altered work schedule/flexitime either necessary or convenient and neither the department nor the employees are unduly affected thereby. In no case shall such altered work schedule/flexitime be approved if to do so would result in a violation of the FLSA or require the payment of overtime compensation.
- B. The Appointing Authority, or the employees' immediate supervisor, when authorized by the Appointing Authority, may offer flexitime in lieu of compensatory time off or overtime if the operational needs of the department require an employee to work more than their assigned hours in a day. The employee may decline flexitime, in which case the employee shall receive either compensatory time off or overtime consistent with the provisions of this MOU.
- 2.36. **Suspension:** Temporary separation of an employee from County service without pay for disciplinary reasons. Suspensions may occur only as a result of a disciplinary action conducted under the provisions of this MOU.
- 2.37. **Transfer:** Movement of an employee from one position to another.
- A. **Demotional Transfer:** Movement of an employee from one position to a different position with a lower rate of pay.
- B. **Lateral Transfer:** Movement of an employee from one position to a different position at the same rate of pay.
- C. **Promotional Transfer:** Movement of an employee from one position to a different

position at a higher rate of pay.

- 2.38. **Y-Rate:** The locking of an employee's pay level when, as the result of a reclassification, an employee would otherwise be placed in a lower classification with a lower pay scale that will continue until the pay scale for the classification in which the employee is working exceeds the level at which the pay was locked.

ARTICLE III GENERAL INFORMATION

- 3.1. **Employee Association:** Employees are eligible to join the Association with the exception of those employees who occupy an Executive Management and Mid-Management/Professional position. Those employees shall not represent an employee or the Association in any disciplinary action or grievance, or meet and confer procedure.
- A. Two (2) designated association members or in their absence, alternates, may participate without loss of compensation on the Board of Supervisors Healthy Workforce Goal Committee.
- 3.2. **Release Time:** The Union Chapter President or designee shall be granted up to twenty-four (24) hours paid release time per month to conduct union business. At least twenty-four (24) hours' notice shall be provided of any intent to use release time under this provision. Additionally, County shall grant up to eight (8) hours of paid release time for the President or designee to attend meetings of the Board of Supervisors whenever an agenda item affects the Union or its members or represented employees. This release time shall be without loss of compensation and shall not be accumulated.
- 3.3. **Union Paid Release Time:** Upon written request of the Union, with not less than ten days advance notice, the County will release any employee without loss of pay to attend union functions or activities for a period not to exceed three (3) business days, consistent with the operational needs of the department. The County will invoice the Union for the cost of payroll and benefits for that employee within thirty (30) days of the lost time, and the Union will reimburse the County in full within thirty (30) days of receiving a timely invoice. The total number of days that may be released under this paragraph shall not exceed fifteen (15) days (120 hours) per calendar year, inclusive of all employees. County may decline to release an employee for more than six days in a year under this paragraph on the grounds of operational needs related to the employee's function in his or her department.
- 3.4. **Use of County Facilities:** The Union is entitled to use County facilities, including computers, network, email and phones and interoffice mail for official union communications. Such use shall be limited in scope and time to actual release or break time and shall not include any long distance phone charges. Additionally, the Union is entitled to use printing facilities belonging to County, at rates charged to other non-County organizations, in accordance with established procedures.
- 3.5. **Release Time for Negotiations:** Union members who serve as the Union's team for bargaining are entitled to paid release time for any scheduled bargaining session, independently of any release time discussed above, and additional time as needed for meetings of the bargaining team when bargaining is open, not to exceed two (2) hours per scheduled bargaining session.
- 3.6. **Direct Deposit:** All new employees hired after the effective date of this Memorandum of Understanding will be required to receive their pay as direct deposit, unless waived by the Human Resources Manager for extraordinary circumstances, under procedures established by the Auditor- Controller.
- 3.7. **Production and Distribution of MOU:** The County agrees to produce and provide copies of this MOU and any amendments later agreed to, if any, to each current employee in the bargaining unit. The County will provide a copy of this MOU and amendments, if any, to new employees upon hire during orientation. The County will endeavor to produce these copies within thirty days of the signing of the MOU and any amendments.

3.8. **Outside Employment:** No full-time Del Norte County appointed official or employee may engage in outside employment unless prior written approval is granted. Outside employment must not be inconsistent, incompatible, in conflict with, or harmful or unfavorable to his or her duties as a County employee, or reduce the efficiency of the employee in County employment. The hours and schedule worked in outside employment should, at a minimum, permit one full day of rest in a calendar week. For specific details, refer to the Personnel Rules policy manual.

3.9. **Seniority Policy:** The purpose of this policy is to define seniority as it is applied. The goal of this policy is to set the provisions that may be uniformly incorporated within the existing policies for scheduling purposes to provide services to the citizens of Del Norte County. The Sheriff has the constitutional responsibility and right to make temporary shift change assignments and/or to assign staff as he/she deems necessary in the best interests and safety of the County, employees, and the general public. The following are definitions and provisions of this policy:

A. **Seniority:** A status attained by length of continuous service.

B. **Continuous Service:** Uninterrupted employment in a position allocated and assigned within the Sheriff's Department, on a continuous paid basis. A leave of absence without pay will not accrue service time towards seniority.

Seniority in the department is established first by rank, and secondly by aggregate time served in rank whether on a regular, assigned, or temporary basis. Where a conflict occurs because of identical service dates of appointment, the employee with the higher position on the eligibility list from which the appointments were made is deemed to be senior.

Seniority shall be calculated based on an employee's date of appointment within a classification except as provided below. The following classifications shall be subject to this provision:

Secretary/Non-Sworn
Employee Dispatcher
Correctional Technician
Correctional Officer
Sergeant/Correctional
Sergeant

Seniority for the classification of Deputy Sheriff/Coroner shall be calculated beginning on the date the individual was appointed to the position of Deputy Sheriff/Coroner I/II/III.

For purposes of seniority within the department, if an employee changes from one of the above listed classifications, their seniority for purposes of selecting shift assignment or days off begins from the date of appointment to the new classification. If however, an employee moves in a descending order, i.e. from deputy sheriff to correctional officer, they shall maintain their seniority for purposes of selecting their shift assignment and days off.

An employee assigned to a specialty position within a respective division shall maintain his/her seniority upon being reassigned back to their original classification.

Seniority will be utilized when determining shift assignment, and days off within a division or unit. Seniority will also be utilized in the granting of requests for vacation, floating holiday, and/or compensatory time off if requested at the same time. Where two or more employees within the same division request time off on the same dates time off will be granted by seniority. Time off shall be granted on a first come, first served basis.

Longevity dates used in calculation of benefits, layoff and reemployment rights shall not be affected by this policy. For purposes of this policy the divisions within the department are as follows:

- Dispatch/Communications Division
- Corrections Division
- Operations Division

ARTICLE IV COMPENSATION & HOURS OF EMPLOYMENT

- 4.1. **Salary Schedule:** The salary schedules for all positions in the bargaining unit are available upon request from the Human Resources Office.
- 4.2. **Cost of Living Adjustment:** In consideration for the agreement of employees to begin paying a percentage of the PERS contribution per Section 9.10, the County agrees to provide Cost of Living Adjustments (COLA's) as follow:
- A. Effective the first full pay period in July 2018, all bargaining unit members defined by CalPERS as "Safety Retirement" will receive a 6.75% salary increase.
 - B. Effective in the first full pay period in July 2018, all bargaining unit members defined by CalPERS as "Miscellaneous" will receive a 4.75% salary increase.
- 4.3. **Concession Bargaining:** If at any time during the term of this Agreement it becomes necessary to participate in concession bargaining Countywide, SEA agrees to participate in the concessions to the equivalent level that which other bargaining units in the County elect.
- 4.4. **Salary Compensation Survey:** The ten (10) previously adopted comparable counties (Amador, Calaveras, Glenn, Inyo, Lassen, Mariposa, Plumas, San Benito, Siskiyou and Trinity) by the Board of Supervisors shall be used to make comparison and determine benchmarks.
- 4.5. **Beginning Salary:** Newly-hired employees shall be compensated at step A of the appropriate salary schedule and range. Where it is difficult to hire qualified personnel or where a person of unusually high qualifications is hired, the appointing authority may request the Board of Supervisors to appoint at a higher step, but in no event higher than step C. The Board of Supervisors must approve appointment at a step higher than step A.
- A. **Recruitment Incentive:** Any new employee hired into the position of Deputy Sheriff who has incurred the cost of the POST Academy at their own expense, shall be eligible for reimbursement of such costs up to a maximum of \$3,000.00 according to the following schedule:

Completion of first year of service:	\$1,000.00
Completion of second year of service:	\$1,000.00
Completion of third year of service:	\$1,000.00

Only those employees hired on or after December 9, 2006 shall be eligible for this benefit. Any payment will be conditional upon successful completion of the Field Training Program and initial probationary period. This Recruitment Incentive Agreement is contingent upon the continuation of funding through the Sheriff's Department AB443 allocation.

B. **Lateral Hires:**

- 1. **Definition of Lateral Hire:** A lateral hire is defined as an experienced California law enforcement officer possessing a valid Basic, Intermediate, Advanced or elevated POST certificate who is not currently employed by Del Norte County.
- 2. **Step Placement:** A law enforcement officer possessing an Advanced POST certificate may be placed at Step D of the appropriate salary range upon approval of the Board of Supervisors provided that any current employee who possess the same qualifications receive the same or equal level of pay as the new hire.
- 3. **Paid Time Off:** Upon hire a lateral hire shall be provided forty-eight (48)

hours of Paid Time Off (PTO) to be used for time off during the first six (6) months of employment. After six months of employment any unused PTO shall be converted to compensatory time. An employee who terminates within the initial six months shall not be entitled to payment for unused PTO.

- C. **Shift Differential:** A Shift Differential shall be provided to those employees working evening shift as defined in Section 4.12 of this MOU. Payment shall be made only for actual time worked between the specified hours in this section. Effective upon ratification of this agreement, the shift differential shall be four percent (4%) of base pay for all classifications.
- D. **Bilingual Pay:** An employee in a position that has been approved by the Appointing Authority and confirmed by the Human Resources Manager as requiring the use of bilingual skills on a continuing basis averaging ten percent (10%) of work time may qualify for bilingual pay. Use of bilingual skills includes any combination of conversational, interpretation, or translation work. The ten percent (10%) standard is verified in writing by the Appointing Authority and confirmed by the Human Resources Manager on a quarterly basis and is based upon the time spent conversing, interpreting or transcribing in a second language.
1. The position must be in a work setting where bilingual skills are required to meet the needs of the public in either a direct public contact position or an institutional setting, or the position is utilized to perform interpretation, translation or specialized bilingual activities in conjunction with the departmental function.
 2. Upon qualification employees in the designated positions shall be compensated at a rate of seventy-five dollars (\$75.00) per pay period. Continuing payment shall be based upon the quarterly verification by the Appointing Authority and confirmed by the Human Resources Manager. In the event of two or more employees in a department with bilingual skills, the Appointing Authority may request certification of those skills and shall appoint from the list of certified employees. If the employees are equally qualified, the more senior employee shall be selected.
 3. Employees currently receiving a bilingual differential based upon five percent (5%) whose differential rate is over seventy-five dollars (\$75.00) shall not be decreased or increased and shall continue at that rate until such time as the five percent (5%) differential is less than the flat rate differential.
- E. **Specialty Assignments:** Some classifications receive compensation differentials based on temporary rotational assignments. In a joint effort to not cause a delay in reaching a timely Agreement, the parties agree to a Side Letter Agreement to amend the list of specialty and rotational assignments. The parties agree to meet within sixty (60) days of ratification for the purpose of clarifying and defining the type of specialty and rotational assignments.
1. **Investigations Differential:** A two and one half percent (2.5%) salary increase shall be provided to those employees who are assigned on a temporary, rotational basis to perform the duties of an investigator.

The Work Assignment Differential may apply to a Sergeant and/or Deputy while assigned to perform investigative duties. The assignment shall be on a rotational and temporary basis as specified in Section 4.5.E.3.

The Work Assignment Differential shall be in addition to other compensation such as education incentive pay, shift differential, etc. The differential shall end in the event the assignment is terminated at the Sheriff's or the employee's

request.

2. **Canine Handler:** The "Canine Handler" is a POST certified law enforcement officer assigned to the Narcotic Enforcement Unit in the Del Norte County Sheriff's Department. For purposes of this selection, the Specialty Position recruitment procedures shall apply. The handler is required to maintain the qualification addressed in the Sheriff's Narcotics Detection Canine Program and the Sheriff's Office Narcotics Canine Manual that include, but are not limited to the following:

- Employed as a Del Norte County Deputy Sheriff II/III with demonstrated satisfactory work performance
- Full-time with a minimum of three years of patrol duty
- Ability to work independently and unsupervised
- Record free of founded excessive force complaints
- Possess a proper attitude toward animals
- Possess a keen ability to communicate professionally
- Possess proficient report writing and record keeping skills
- Ability to exhibit a calm professional manner in dealing with stressful situations
- Be in good physical health
- Reside in an adequately fenced, single-family residence (minimum 5-foot high fence with locking gates)
- Live within 30 minutes travel time from Del Norte County Sheriff Office, currently located at 650 5th Street, Crescent City, CA
- Agree to be assigned to the position for a minimum of 3 years
- Successfully complete and maintain POST requirements for canine certification

Additional compensation shall be paid based upon the state minimum wage, paid at time and one-half for forty-five (45) minutes per day, seven (7) days per week unless the canine is out of the handler's care such as being boarded or other reasons. The handler shall notify the Sheriff if the 45 minutes per day care time is exceeded. Consistently earned compensation in excess of 45 minutes shall be cause for change in handlers.

The canine handler will be assigned an appropriately equipped vehicle for transporting the canine. The vehicle shall be maintained in a clean and orderly manner, free from dog hairs and other substances. Time spent cleaning and maintaining the canine vehicle is compensable work time paid at the state minimum wage not to exceed one (1) hour per week. Commute time to and from work with the assigned canine is not compensable.

3. **Rotation Assignments:** All special assignments, as listed below, shall be on a two (2) year rotational basis, with an extension of this time period at the discretion of the Sheriff. Assignments include, but are not limited to:

Boating Safety or Investigator (including tribal funded investigator positions)

Only permanent, full-time deputies shall be eligible to apply for specialty assignments. Appointment to a specialty assignment will follow the recruitment process established in the Human Resources Department Recruitment Policy, with the Sheriff making the final selection.

- F. **Training Officer Differential:** Employees, who are assigned long term field

training duties in patrol, jail, or dispatch, as assigned by the Sheriff, shall receive a differential of five percent (5%). This shall be in addition to all other compensation provided for under this MOU.

- G. **Education/P.O.S.T Incentive:** Effective upon ratification of this agreement, the County shall provide additional compensation to those employees who have completed the requirements for an Associates of Arts Degree and/or Bachelor's Degree, or who possess a P.O.S.T. Intermediate or Advanced Certificate. The additional compensation shall be as follows:

AA or equivalent degree or Intermediate P.O.S.T Certificate: 2.5% of base salary.

BA or equivalent degree or Advanced P.O.S.T. Certificate: 5.0% of base salary.

Employees attaining professional certifications that result in a salary increase shall be compensated effective the first day of the following pay period from the date of issuance of such certification. Those employees currently receiving education and P.O.S.T. incentive pay shall continue to receive this pay until such time as the employee separates from County employment. Cumulative Incentive pay shall not apply to those employees not presently receiving such compensation.

- H. **Re-employment:** An individual may be re-employed on a permanent basis without the normal recruitment procedure, upon the written request of the Appointing Authority and approval by the Human Resources Manager, provided the individual had occupied the same or higher classification; left County employment in good standing within twelve (12) months of the proposed re-hire date and possess current qualifications for that position. Individuals seeking re-employment must demonstrate the ability to meet the requirements of the job, which may include a written test, agility and strength exam, a physical examination and psychological evaluation. Compensation and benefits shall be provided under the same provisions as a new employee.

- I. **Employment Restrictions:** An applicant will not be considered for employment who:
1. Is a member of the immediate family of a member of the Board of Supervisors.
 2. Has a member of his/her immediate family already employed by the County, unless the Human Resources Manager determines that such employment would not adversely affect the right of the County to reasonably regulate, for reasons of supervision, safety, security or morale of the working of members of immediate family in the same department, division or facility.
 3. Should employees, who are employed in the same department marry, unless the Human Resources Manager determines that the marriage will not adversely affect the right of the County to reasonably regulate, for reasons of supervision, safety, security or morale, the working of spouses in the same department, division, division or facility, then within ninety (90) days, one shall transfer to another department or if no other position is available for transfer, the spouse with the least seniority shall be laid off at the close of the 90-day period.

- 4.6 **Probationary and Annual Salary Increases:** Employees who are subject to a six (6) month or twelve (12) month probationary period, who attain permanent status shall progress from their current step to the next step within a range on the salary schedule effective on their annual evaluation date, twelve (12) months from the date of hire or promotion. Employees shall progress from one step to the next within a range on the salary schedule each year on the employee's anniversary date until step E is attained, provided the employee's work performance rating is at a satisfactory level or above. In the event of a below satisfactory

rating, the step increase shall be effective upon attaining a satisfactory rating following completion of a performance improvement plan. The Appointing Authority will make recommendation to the Human Resources Manager for approval. Any employee whose performance is determined below satisfactory shall be given ten (10) working days' notice prior to the step increase due date that a step increase will not be provided.

- 4.7. **Longevity Step Increases:** After completion often (10) years of uninterrupted, continuous service an employee shall advance to step F of the appropriate range. After completion of fifteen (15) years of uninterrupted, continuous service, an employee shall advance to step G of the appropriate range. After completion of twenty (20) years of uninterrupted, continuous service, an employee shall advance to step H of the appropriate range; after completion of twenty-five (25) years of uninterrupted, continuous service, an employee shall advance to step I; after completion of thirty (30) years of uninterrupted, continuous service, an employee shall advance to step J. An employee on step F, G, H, I or J, if promoted, will remain at their longevity step in the new salary range.
- 4.8. **Step Placement After Promotion or Open Hiring:** If an employee is promoted or applies and is selected through open hiring for a position in a higher class, the employee shall be placed at the lowest step of the new salary range that insures a minimum of a five percent (5%) increase in salary; provided, however, that this provision shall not conflict with Section 4.5. In the event the promotion or open hiring for a position in a higher class places the employee in a class paid less than five percent (5%) more than the old class, the employee will be placed at the same step in the new range that he or she held in the old range.
- 4.9. **Y-Rating:** An employee who is Y-Rated shall continue to receive the exact biweekly salary received at the time the Y-Rate is implemented, until such time as the dollar value of the salary range to which he or she is assigned increases to a level above the Y-Rate placement, at which time the employee will again be eligible for step and cost-of-living increases.
- 4.10. **Working Out of Class:** This provision shall apply when an employee is specifically assigned by the Appointing Authority or designee and performs, on a temporary basis, the full range of duties of a higher-level position, in which there is no incumbent or in which the incumbent is on a paid or unpaid leave of absence, or is for some other reason away from the job. Compensation shall be at the pay rate of the higher-level position, and shall be calculated as though the employee had been promoted to the higher-level position.
- A. Employees, except those provided for in B and C below, shall be compensated at the higher rate from the first day provided they work at least five (5) consecutive days in the higher-level position.
 - B. Employees designated as mid-management/professional shall be compensated after working twenty (20) consecutive days in the higher level position.
 - C. Employees whose job description includes assuming the duties of a higher-level position shall be compensated at a higher rate commencing with the sixth consecutive day, provided the employee is not designated mid-management/professional or exempt.
 - D. When an employee is assigned part of the job duties of a higher-level position, the employee shall be compensated an equivalent or adequate differential. The compensation shall be paid in the manner provided for in subsection A, B, or C, above. Differentials shall be recommended by the Appointing Authority based upon the amount of higher-level duties assigned to the employee, with final approval by the Human Resources Manager. The differential shall be a flat amount and shall not exceed the amount that would be paid had the employee been promoted.
 - E. Prior to an authorized out of classification assignment, the Appointing Authority or

designee shall meet with the affected employee(s) and make a determination in writing as to what duties will be performed and the duration of the assignment, if known. The determination and proposed proportionate compensation shall be forwarded to the Human Resources Manager for approval. All out of classification assignments shall be reviewed on a quarterly basis by Human Resources and approved by the Appointing Authority.

4.11. **Pay Day:** All employees shall be paid on a bi-weekly basis. If a normal bi-weekly pay day falls on a holiday, the payday shall be the last regular working/business day before the holiday or holidays. The pay period runs from Friday through the second following Thursday, paid on the Friday of the following week. Direct deposit is available through the payroll office.

4.12. **Hours of Work:** Specific classifications within the Sheriff/Jail divisions have been designated to work ten (10) hour and twelve (12) hour shifts to provide adequate coverage and staffing pursuant to Article II, Section 2.35.

A. **Ten Hour Shifts:** The following is a list of the ten (10) hour shift classifications and provisions.

1. Investigators will generally work from 8:00 A.M. to 6:00 P.M. The Sheriff and the Association shall mutually agree on permanent days off. These work hours and days off may be modified by mutual agreement between the department and the employee for special investigative details or in the event of an emergency.
2. Boating safety and deputy sheriff work hours and days off will be determined by the department for specific duty needs. These work hours and days off may be modified by mutual agreement between the Sheriff and the employee for special details or in the event of an emergency.
3. Days off selection shall be pursuant to the Seniority Policy in Article III, Section 3.5 of this MOU.
4. Shift differential will apply to any shift or hours worked between 6:00 P.M. and 6:00 A.M.
5. Overtime shall be paid for hours worked in excess of the regularly scheduled ten (10) hour shift per day.
6. Vacation hours shall continue to accrue biweekly based upon an eighty (80) hour pay period equivalent to the provisions of Article V, Section 5.3.

B. **Twelve Hour Shifts:** The following is a list of the twelve (12) hour shift classifications and provisions.

1. Dayshifts will start at 6:00 A.M. and end at 6:00 P.M. Evening shifts will start at 6:00 P.M. and end at 6:00 A.M. Selection of days off shall be pursuant to the Seniority Policy in Article III, Section 3.9 of this MOU.
2. Shift differential will apply to any shift or hours worked between 6:00 P.M. and 6:00 A.M.
3. Overtime shall be paid for hours worked in excess of the regularly scheduled, twelve (12) hours per day.
4. Vacation hours shall continue to accrue bi-weekly based upon an eighty (80) hour pay period equivalent to the provisions of Article V, Section 5.3.
5. Designated classifications include Deputy Sheriff, Sergeants, Dispatcher, Correctional Officer/Correctional Technician (jail security personnel); excluding those deputies, sergeants and/or correctional officers assigned to Boating Safety, Court Bailiff and Detective.

C. **Altered Work Schedule:** The Appointing Authority, with the approval of the Human Resources Manager, may establish an alternative work schedule for employees of the department. Eligibility, participation in and implementation of any such work schedules shall be at the sole discretion of the Appointing Authority.

1. The Appointing Authority, or the employees' immediate supervisor, when authorized by the Appointing Authority, may authorize an employee to work an altered work schedule where the needs of the employee make an altered work schedule either necessary or convenient and neither the department nor the employees are unduly affected thereby. In no case shall such altered work schedule be approved if to do so would result in a violation of the FLSA or require the payment of overtime compensation.
2. Any employee or group of employees desiring an alternative schedule may request, in writing, that the department establishes such a schedule. Such a request shall be considered by the Appointing Authority, but shall not require the establishment of or assignment to such a shift. The Appointing Authority shall have fourteen (14) calendar days to notify the employee or group of employees of his or her decision in writing with the reasons for the decision explained.
3. Long Term Altered Work Schedules: The Appointing Authority, at the request of the employee(s), may establish long term alternate work schedules for individual employees or groups of employees. Alternative work schedules include, but are not limited to, for purposes of this paragraph: four (4) ten (10) hour days (also known as 4 ten 40's), 9 eight 80's, which consists of eight 9-hour workdays, on 8-hour workday and one additional day off every other work week, and a weekly work schedule consisting of forty (40) work hours during five (5) work days at other than traditionally scheduled hours for the assigned shift. Establishment of an alternative work schedule shall be approved if it is consistent with operational requirements. The request, and the approval or denial, shall be in writing. Permanent changes or cancellations of the alternate work schedule for cause shall not be made without fourteen (14) days' notice to the affected parties. Any proposed termination of such schedule shall be appealable to the Appointing Authority within five (5) working days of notification of its termination. The Appointing Authority's decision shall be final and not subject to grievance under Article XI of this MOU. In no case shall alternate work schedules be approved if to do so would result in a violation of the Fair Labor Standards Act or require payment of overtime compensation.

4.13. **Overtime:** Employees shall not work overtime except when necessary and required by the appointing authority. Department Heads shall not authorize overtime for routine tasks that must be accomplished on a routine basis. Employees may not take vacation on a day on which they also work, if the combined work time and vacation would exceed the employees regularly assigned non-overtime working hours for the day. Department Heads shall not authorize any vacation time which could result in overtime for an employee on a daily or weekly basis, except where this overtime is absolutely necessary to meet the emergency needs of the department.

- A. Overtime shall be paid for all hours worked in excess of the employee's regularly scheduled eight (8) hours, ten (ten) hours, or twelve (12) hours workday, unless the employee is working an altered work schedule as defined in Section 4.12.C.
- B. Overtime shall be paid for all hours worked in excess of the employee's regular working/business day as defined in this section.
- C. Overtime shall be paid for all hours worked in excess of the employee's regularly

assigned thirty-six (36), forty (40), or forty-four (44) hour workweek.

- D. For all employees, except those exempt from overtime compensation under the Fair Labor Standards Act, a rate of time-and-one-half the employee's regular rate of pay shall be paid for hours worked under the three preceding subsections. The standard to be met for employee entitlement to overtime compensation, for those employees entitled to overtime compensation under the Fair Labor Standards Act, is overtime work which is suffered or permitted by the County.
- E. Holidays and vacation hours shall be considered hours worked for the purpose of calculating overtime. Sick time and compensatory time off shall not be considered hours worked for the purposes of calculating overtime.
 - 1. Compensation for overtime will not be granted to those positions designated as exempt from overtime compensation under the Fair Labor Standards Act, except where specifically provided for in this MOU.
 - 2. Nothing in these provisions shall limit the employee's right to overtime compensation as provided in the Fair Labor Standards Act.
- F. Executive management, management and exempt employees will not be authorized overtime; provided, however, those employees may earn compensatory time off. When any of these employees is not an exempt employee under the provisions of the Fair Labor Standards Act, that employee shall be entitled to overtime compensation as provided in the Act.
- G. Employees shall accrue no more than three (3) weeks regular working hours for use as compensatory time off; provided that in an emergency, if an employee accrues more than that which is allowed, it can be granted by the Department Head with the approval of the Human Resources Manager.
- H. Nothing in these provisions shall limit an employee's right to compensation for overtime earned as provided in the Fair Labor Standards Act.

4.14 **Compensatory Time Off:** The Appointing Authority shall determine whether employees receive overtime pay or compensatory time off for overtime worked, subject to the following conditions:

- A. If an FLSA covered non-exempt employee is required to work overtime, above, the Appointing Authority may opt to provide, in lieu of overtime rates, corresponding compensatory time off at the corresponding rate. For example, an hour of time equals one and one half (1.5) hours of compensatory time off. Employees may accumulate up to 120 hours of compensatory time off, provided that in an emergency, if an employee accrues more than that which is allowed, the Appointing Authority, with the approval of the Human Resources Manager, can permit additional hours.

4.15. **Court Time:** Court time compensation applies when an employee is required to appear in court in his/her capacity as a peace officer or correctional officer. Actual attendance at court shall be considered time worked for the purpose of calculation of overtime.

- A. When an employee is required to appear in court and is not scheduled to be on duty, during the time of his/her appearance, upon report to the court the employee shall receive a minimum of four (4) hours pay or the actual amount of time spent in court, after overtime calculation, whichever is greater. When such court appearance on off-duty time requires to employee to be in attendance before and after the lunch recess, such lunch time will be included in determining the employee's court overtime.
- B. When the employee's court appearance is scheduled within two (2) hours prior to the beginning of the employee's work hours, the employee will be compensated for a minimum of two (2) hours for such court appearance.

- C. When an employee's court appearance is cancelled after the close of his or her work shift and more than three (3) hours before the appearance, the employee shall receive three (3) hours compensation.
 - D. Notice of cancellation less than three (3) hours before the appearance time shall be treated as an appearance and the employee shall receive four (4) hours compensation. If notice of cancellation occurs prior to the close of his/her work shift, there shall be no compensation.
- 4.16. **Travel Time:** Commuting between home and the work site is not normally work time and is not included as working hours for purposes of compensation or overtime computations.
- A. Unusual home to work travel may be working time if the employee is required to travel substantial distances to a place other than his or her normal worksite outside of the normal work shift. This provision applies where, following the employee's normal work shift, the employee is called out for emergency services at other than the normal work place, and the distance traveled is in excess of five miles.
 - B. Additionally, travel in connection with a special "one day" assignment away from the regular work site which requires travel of a substantial distance, (greater than five miles each way) will be considered working time.
 - C. Travel where work is being performed during the travel is work time. This includes work transporting people, goods or waste.
- 4.17. **Travel Away From Home:** Travel on overnight trips away from home is working time during normal working hours, regardless of whether or not it is a normal work day. Where the normal working days are Monday through Friday, 8:45 AM - 5:45 PM, for example, travel on any day Sunday through Saturday, during these hours, would be working time regardless of how the travel is accomplished. The County Travel Policy should be reviewed for all County related travel.
- A. Overnight travel on trips away from home outside of normal working hours is working time only when the travel is not accomplished with public transportation and the employee is required to travel by private automobile, whether or not the employee is the driver or a passenger.
 - B. Travel as a passenger on public transportation outside of normal working hours is not working time.
 - C. When an employee is offered public transportation for overnight travel away from home but requests permission to drive his/her own vehicle, only that travel time which would have been working time if the employee had taken the public transportation will be considered working time while traveling in his/her own vehicle. Passengers who make this election are likewise governed by this provision.
 - D. Commercial flights are public transportation under this Article.
- 4.18. **Exclusions From Compensated Travel Time:** Regular meal periods while traveling are not working time. When an employee's regular work shift includes a regular meal period such as lunch or dinner, the regular length of that meal period will be excluded from working time while traveling.
- A. Any time spent as an employee sleeping or consuming meals while traveling, when the accommodations and/or the meals are furnished at County expense, are not working time.
 - B. Any time spent on activities of a personal nature, such as visiting friends or relatives, sightseeing, or the like, while traveling at the destination point, or enroute, is not working time.
 - C. Nothing in these provisions shall deprive any employee of compensation provided in the

FLSA.

4.19. **Reimbursed Mileage and Transportation:** Employees required to travel outside Del Norte County shall complete a travel request form which must be approved by the appointing authority. For purposes of this section, travel means by air or ground service. The purpose for travel must be attached to all claims such as meeting, board conference or training program agenda. Questions of reasonableness as to expenses for transportation and travel will be determined by the Auditor-Controller. The County will not pay for any costs incurred by or related to a spouse or companion.

- A. Reimbursement for travel expenses, including airfare or mileage shall be at the actual reasonable cost. Employees shall obtain receipts whenever practicable, and attach them to the cover sheet. If the employee is unable to obtain a receipt, an explanation must be provided on the travel voucher. Questions of reasonableness will be adjudicated by Auditor-Controller.
- B. The guidelines and amount approved by the Internal Revenue Service (IRS) determine the reimbursement rate for each mile traveled on County business.
- C. Travel between home and office is not reimbursable.
- D. Travel from office to office, and return, on County business, is reimbursable.
- E. Travel between home and County business destination (excluding office) may be partially reimbursable. Mileage shall be computed from the employee's designated workplace. If travel begins from the employee's residence, mileage shall be calculated from the residence or workplace, whichever is less.

4.20. **Reimbursed Lodging:** When it is necessary for employees to be lodged overnight out of the area while on approved County business, County will reimburse employees for actual cost of the room as evidenced by an itemized receipt issued by the hotel or motel, with the following limitations:

- A. All lodging reimbursements require an itemized receipt issued by the motel. Lodging charges shall not exceed \$225.00 per night, plus tax, single occupancy. County Administrative Officer may approve extraordinary costs above these limits on a case-by-case basis when the responsible Appointing Authority and County Administrative Officer determine that higher cost is unavoidable, or is in the best interest of the County.

4.21. **Reimbursed Meals:** Reimbursement for meals shall be as follows: \$10.00 for breakfast, \$10.00 for lunch, and \$20.00 for dinner.

- A. The following guidelines determine the time frame applicable for reimbursement of meal expenses:

Meal	Travel Begins on or before	Travel Ends on or After
Breakfast	6AM	8AM
Lunch	11AM	1PM
Dinner	5PM	7PM

- B. The per diem is the maximum to which an employee will be entitled unless attending a conference or training event in which the employee was charged more for a specific meal. In this case, the employee will be reimbursed the additional amount upon presentation of evidence (registration) of the higher charge.
- C. To be reimbursed for meals, an employee need not include receipts in his or her claim to the Auditor-Controller. Receipts may be required by the Auditor-Controller where reimbursement from another agency is involved.
- D. The claim form requires that the employee certify on a daily basis the amount expended on meals. Where more than one day of travel is involved, the employee shall be

reimbursed no more than the daily maximum multiplied by the number of days involved. Partial days shall be subject to the maximums listed.

- E. An exception to the above limitation: When meals are included in the registration cost for a conference or seminar, the actual cost of the meal will be paid as part of the registration fee. A separate per diem payment for that meal will not be allowed. In the event of a special dietary need of an employee, the Appointing Authority may authorize reasonable accommodations for travel, lodging and meals. If a traditional breakfast meal is not provided, the above breakfast meal allowance will be reimbursed.
 - F. No reimbursement shall be made for alcoholic beverages.
 - G. Per the Attorney General, it is not lawful for public entities to expend funds to reimburse agency employees or officers of their expenses buying meals for legislators or their aids at meetings to discuss legislation of interest to the County.
- 4.22. **Reimbursement for Incidentals:** In addition to travel, lodging and meal expenses, employees who incur reasonable incidental expenses such as, but not limited to, parking, ferry, bus, taxi fare, and rental cars while on approved County business will be approved for the actual and necessary costs. Receipts are required for any amount over \$6.00. Additionally, other incidental expenses in the amount of \$6.00 per day will be allowed for travel involving an overnight stay.
- 4.23. **Excess Unusual Expenses:** Whenever an employee incurs expenses in excess of the maximums set forth above, or when circumstances rendering expenses necessary that are normally not covered, the Auditor-Controller may reimburse the employee for the excess if the employee establishes to the satisfaction of the Auditor-Controller that the expense was, in fact, incurred and that the expense was necessary in light of all of the circumstances.
- 4.24. **Appeal:** If an employee is not satisfied with the disposition of the claim by the Auditor-Controller, a final determination may be sought from the Board of Supervisors.
- 4.25. **Tax Consequences of Travel Reimbursement:** Travel reimbursements may or may not have tax consequences for the employee. Employees may wish to keep receipts even if they are receiving per diems for tax reasons. By requiring the employee to account for his or her expenses, the County has sought to avoid the requirement that all reimbursements be reported as income to the employee. Employees should be aware of the fact that audits by federal or state tax authorities may necessitate retention of receipts. By not requiring receipts for certain expenses, the burden of producing receipts in the event of an audit is on the employee.
- 4.26. **Expense Advance:** Except where otherwise approved by the Board of Supervisors, an advance of a minimum of seventy-five (\$75.00) per day may be provided to employees to help defray the expense of a trip. Employees must obtain approval of the Appointing Authority of advances prior to their submission. The advance to be given to the employee will be determined by the Auditor Controller, taking into account the circumstances under which the trip is being made with the intent that the employee may secure in advanced up to ninety percent (90%) of the anticipated out of pocket expenses. The following expenses are not included in calculating the maximum advance:
- A. Any expense which has been prepaid by County.
 - B. Any expense which may be incurred by the employee by use of a County or department credit card.
 - C. Mileage expenses where the trip is being made in the employee's personal vehicle.
- 4.27. **Mileage Expenses:** Travel within the County shall be by County vehicle whenever possible.

When the personal vehicle of an employee is used for a trip the reimbursement shall be set at the maximum rate allowed by federal regulations with the taxable status of the reimbursement (IRS mileage rates.)

- A. Mileage reimbursement shall not exceed the cost of airfare to the same destination, including reasonable transportation costs at the destination and to and from the departure airport.
 - B. An advance for mileage expenses may be made by the Auditor-Controller not to exceed 90% of the current reimbursement rate.
- 4.28. **Training Attendance:** Employees shall not be required or pressured to attend training sessions or seminars unless the County pays all actual and necessary costs.
- 4.29. **Assigned Standby:** Employees who are assigned standby duty by their Appointing Authority on weekends, overnight or on holidays shall be compensated or given compensatory time off in accordance with this Section. For purposes of this Section, "assigned standby" shall be defined as a period of time during which an employee designated by his or her appointing authority shall be available to provide services when needed. "Available" means that, during the entire standby period, the employee can be contacted immediately by those in need of the services, either by telephone or other means of communication, and that the employee is able to commence providing the services within thirty (30) minutes of the contact. "Commence providing services" means either to give the needed service on the telephone or other means of communication, or to proceed to the location where the services are to be performed.
- A. An employee shall be compensated at his or her normal rate of pay or be given compensatory time off at the rate of one (1) hour for each eight (8) hours, ten (10) hours, or twelve (12) hours of assigned standby time, excluding any hour during which the employee is paid or given compensatory time off for performing services pursuant to the subsection which follows.
 - B. When an employee performs services during an assigned standby period, he or she shall be compensated or given compensatory time off at the rate of one (1) hour for each hour worked. When the work performed qualifies for overtime compensation under Section 4.9 and 4.10, compensation or compensatory time off shall be granted at the appropriate overtime rate. However, in all cases the employee shall be compensated or given compensatory time off for a minimum of two (2) hours.
- 4.30. **Call-Back Time:** Employees shall be compensated for call-back time. Call-back time is defined as only those instances when an employee is ordered back to work without prior notice after completing a shift and leaving the work site. The use of call-back shall be resorted to only in emergency situations or unusual instances when it is not possible for the work to be accomplished through normal scheduling or scheduling of overtime. Responses to phone calls or working at home shall not be considered call-back duty. Travel time shall be compensable as provided in Section 4.11. An employee who is called back shall be compensated for a minimum of two (2) hours of work time. The two (2) hours, whether or not actually worked, are subject to the appropriate overtime provisions. Call-back time earned shall be compensated by pay or compensatory time off as determined by the appointing authority.
- 4.31. **Rest Breaks:** Except as otherwise provided by law, all employees shall be entitled to one (1) fifteen (15) minute rest break for each four (4) hours worked. The employee may take the break away from the work station, provided transit time is included in the fifteen (15) minute period. Appointing Authority or designee shall schedule individual employee's rest breaks so as to provide for the proper and efficient administration of the department's function. At twenty-four hour facilities, employees may be required to remain on premises where

necessary to comply with applicable State and Federal Regulations.

- 4.32. **Meal Break:** All employees are entitled to take a meal break of not less than thirty (30) minutes during any shift of at least ten (10) hours. Employees may take the break away from the work station, provided transit time is included in the meal period. Department heads may stagger meal breaks to ensure coverage. At twenty-four (24) hour facilities, employees may be required to remain on premises where necessary to comply with applicable State and Federal Regulations.
- 4.32 **Public Records Request:** Certain employee information may be required to be released under the California Public Records Act in accordance with Government Code 6250, et. seq.

ARTICLE V AUTHORIZED ABSENCE

5.1 **Entitlement:** All permanent full-time, permanent part-time, probationary and provisional employees are entitled to an authorized absence subject to the provisions and exceptions of this Article.

- A. Permanent part-time employees receive paid holidays, vacation and sick leave based upon the position's allocated percentage of full-time. For example, an allocated position that works twenty (20) hours a work week in a forty (40) hour work week will earn fifty percent (50%) of the amount is earned by a full-time employee.
- B. Employees entitled to holidays, vacation and sick leave shall accrue floating holidays, vacation and sick leave from the date of employment. Sick leave and floating holidays may be used upon accrual. Vacation will be available for use after completion of six (6) months of continuous employment.
- C. For purposes of scheduling employee time off for vacation, compensatory time off, personal floating holidays or regular holidays, the employee shall request time off in writing in advance with his or her Appointing Authority or designee. Approval of all requests shall be governed by the needs of the department. However, employee requests shall not be denied unless operational necessity requires it. A denial shall be provided to the employee in writing, and must state the reason for the denial. Once the Appointing Authority or designee and the employee have agreed to a particular day or days off, the employee shall be allowed to take those days off, unless an emergency occurs rendering the employee's attendance necessary. This procedure shall also apply for scheduling purposes, whenever possible, for family sick leave and medical appointments. The Appointing Authority or designee may require an employee to take off accumulated compensatory time which would exceed the maximum amount which may be accrued in accordance with the provisions of this MOU, by giving an employee not less than forty-eight (48) hours' notice.
- D. If an employee takes a ten (10) hour scheduled workday off for either, vacation, sick leave or compensatory time-off, ten (10) hours will be deducted from the appropriate accrued time balance.
- E. If an employee takes a twelve (12) hour scheduled workday off for either, vacation, sick leave or compensatory time-off, twelve (12) hours will be deducted from the appropriate accrued time balance. If the employee takes an eight (8) hour scheduled workday off either, vacation, sick leave or compensatory time-off, eight (8) hours will be deducted from the appropriate accrued time balance.

5.2 **Holidays:** Eligible employees are entitled to the following holidays with pay up to a maximum of eight (8) hours:

New Year's Day.....	January 1
Martin Luther King Jr. Day.....	Third Monday in January
Lincoln's Birthday.....	Friday prior to third Monday in February
Washington's Birthday.....	Third Monday in February
Cesar Chavez Day.....	Last Monday in March
Memorial Day.....	Last Monday in May
Independence Day.....	July 4
Labor Day.....	First Monday in September
Veteran's Day.....	November 11
Thanksgiving Day.....	Thursday in November
Day after Thanksgiving	Fourth Friday in November

Work day before or after the Christmas holiday and Christmas Day.....December 25th or when:
 Dec. 25th falls on a Monday, the paid holidays shall be Monday 12/25 & Tuesday 12/26
 Dec. 25th falls on a Tuesday, the paid holidays shall be Monday 12/24 & Tuesday 12/25
 Dec. 25th falls on a Wednesday, the paid holidays shall be Tuesday 12/24 & Wed. 12/25
 Dec. 25th falls on a Thursday, the paid holidays shall be Thursday 12/25 & Friday 12/26
 Dec 25th falls on a Friday, the paid holidays shall be Thursday 12/24 & Friday 12/25
 Dec 25th falls on a Saturday, the paid holidays shall be Thursday 12/23 & Friday 12/24
 Dec 25th falls on a Sunday, the paid holidays shall be Friday 12/23 & Monday 12/26

- A. In addition, eligible employees will accrue three (3) (twenty four (24) hours) floating holidays per fiscal year. Employees hired during the period July 1 through December 31 are eligible for three (3) holidays during the first fiscal year of employment. Employees hired during the period January 1 through March 31 are eligible for two (2) (sixteen (16) hours) holidays during the first fiscal year of employment. Employees hired during the period April 1 through June 30 are not eligible for a floating holiday. These holidays may be used at any time with the approval of the appointing authority. Floating holidays may only be used in full day increments; they may not be taken on an hourly basis. If not taken by or before the last pay period of the fiscal year during which they are earned, the holidays are forfeited. Floating holidays accrued but not used may not be paid off at the time of termination of employment.
- B. Accrued floating holidays must be taken in eight (8) hour increments. Employees assigned to twelve (12) hour shifts may use floating holidays in either eight (8) hour increments or twelve (12) hour (two 6-hour) increments. In the event a floating holiday is taken on a scheduled ten (10) hour shift the balance (2 hours), shall be deducted from accrued vacation hours or compensatory time. In the event a floating holiday is taken on a scheduled twelve (12) hour shift, the full amount of the scheduled shift will be deducted from the floating holiday balance. Should the balance not cover the full shift, vacation or compensatory time shall be used to supplement the remaining balance up to twelve (12) hours.
- C. If a holiday falls on a Saturday, the preceding Friday shall be a holiday. If a holiday falls on a Sunday, the following Monday shall be a holiday. Those departments which regularly operate on a twenty-four (24) hour schedule shall recognize holidays as defined in Section 5.2A. Employees assigned to a twenty-four (24) hour facility shall be compensated with additional pay equal to the length of the workday maximum of eight (8) hours when required to work on a holiday, or if the employee's regular day off falls on a holiday.
- D. Employees shall be given the option of receiving holiday pay in a "lump sum" the first pay period in December of each year or receiving the pay as each individual holiday arises effective January 1, 1998. This option must be chosen by December 1, 1997 for the 1998 holidays and by December 15 or each year thereafter. The option shall be irrevocable until the following December. New hires who wish to "bank" holidays must elect to do so within thirty days immediately following their employment. In the event an employee fails to make a decision, holiday pay will be provided as each holiday arises.
- E. Holiday pay for those working ten (10) hour shifts will remain paid at eight (8) hours whether pooled for "lump sum" payment or taken. In no event shall the holiday pay exceed eight (8) hours, accrued vacation or compensatory time shall be used for the two (2) hour difference when necessary to maintain the eighty (80) hour pay period.
- F. Holiday pay for those working twelve (12) hour shifts will remain paid at eight (8) hours whether pooled for "lump sum" payment or taken. In no event shall the holiday pay exceed eight (8) hours, accrued vacation or compensatory time shall be used for

the four (4) hour difference when necessary to maintain the eighty (80) hour pay period

- G. In addition to the above holidays, the Board of Supervisors may declare as an additional holiday each day declared by the President of the United States or the Governor of the State of California as a day of mourning, thanksgiving, or a special occasion. Each day so declared shall be treated as a holiday.

5.3 **Vacation:** Eligible employees are entitled to paid vacation as follows:

- A. Employees shall accrue vacation at a rate equal to the following annual vacation days: five (5) days (40 hours) during the first (1st) year of continuous service; ten (10) days (80 hours) per year for two (2) through five (5) years of continuous service; fifteen (15) days (120 hours) per year for six (6) through ten (10) years of continuous service; twenty (20) days (160 hours) per year for 11 (eleven) through fifteen (15) years of continuous service; and twenty- five (25) days (200 hours) per year for sixteen (16) or more years of continuous service.
- B. Employees designated by the Board of Supervisors as line supervisor, mid-management, professional or confidential shall be entitled to five (5) days of vacation per year in addition to the time provided under Section 5.3.A above.
- C. An employee who terminates during the initial six (6) months of service shall not be entitled to vacation leave or payment for accrued vacation.
- D. At no time may employees accrue more than the number of days of vacation they are entitled to earn in a two (2) year period at their current rate of accrual. Employees who have reached this limit cease accruing vacation until such time as the total number of days accrued is less than this number.
1. Employees whose vacation accrual balance exceeds the two (2) year cap as of the effective date of this agreement shall have those excess hours placed into a separate bank for their use. This excess bank may be drawn from at any time at an hour-for-hour rate should the employee exhaust their accrued vacation.
 2. Employees eligible for vacation usage shall be compensated for unused vacation leave upon separation from service. Employees who, upon separation from service, have hours accumulated in an excess bank as described in Section 5.3.D. above shall have those remaining hours compensated at the hourly rate at which the hours were deposited in the excess bank as of the effective date of this agreement.
 3. Vacation shall continue to accrue while an employee is on other paid leave of absence or temporary disability. Accrued vacation may be used to supplement paid leave or temporary disability benefits at the employee's request.

5.4 **Vacation Scheduling:** Employees shall request time off in writing in advance with his or her Appointing Authority or designee. Vacation scheduling is pursuant to the Seniority Policy in Article III, Section 3.9. Vacation requests shall not be denied unless operational needs of the department so dictate. A vacation denial shall be provided to the employee in writing and must state the reason for the denial. Once the Appointing Authority and the employee have agreed to a particular day or days off, the employee shall be allowed to take those days off, unless an emergency occurs rendering the employee's attendance necessary.

5.5 **Use of Banked CTO:** An employee shall request the use of CTO in writing, on the County provided form. The Appointing Authority or designee shall grant the employee's request to use CTO within a reasonable period of time, not to exceed sixty (60) days, unless granting the request would unduly disrupt operations, which means, would create an unreasonable burden on the County's ability to provide services of acceptable quality and quantity for the public during the time requested without the employee's services. Departments shall, to the extent practical, grant

requests for particular days off, if it is consistent with operational needs.

- 5.6 **Sick Leave:** All eligible employees are entitled to sick leave with pay. Employees are expected to work a complete designated workday. If an employee cannot report to work, the employee shall notify his or her department as early as possible, but not later than two (2) hours after the workday begins. Sick leave entitlement is as follows:
- A. Eligible employees earn a rate of one (1) day of sick leave with pay for each month of service from the date of employment, accrued on a biweekly basis.
 - B. Sick leave will only be authorized for illness of an employee, his or her immediate family as defined in Article II, Section 2.23. Abuse of this sick leave provision shall be cause for discipline. The Appointing Authority is responsible for insuring that the sick leave is not misused. With prior approval from the Human Resources Manager, the Appointing Authority or designee may require medical certification or other substantiating evidence of illness for absences of five (5) consecutively schedule work days for which sick leave is sought. Verification of sick leave may be requested of employee within a reasonable amount of time upon the employee's return to work.
 - C. Human Resources may require employees returning to work after a lengthy sick leave in excess of ten (10) continuous working days to present return to work documentation from a qualified health care provider verifying that the employee is able to perform the essential functions of the job position, with or without restrictions. Such verification shall be submitted directly to Human Resources prior to the employee returning to work.
 - D. Sick leave may be used for purposes such as: illness or injury, medical, mental health or dental appointments for the employee or for his or her immediate family members as defined in Article II, Section 2.23. of this MOU
 - E. Those employees separating in good standing with between five (5) and ten (10) years of continuous service shall be compensated at a rate of ten percent (10%) for accumulated unused sick leave.
 - F. Upon separation from County employment in good standing, those employees with ten (10) or more years of continuous service shall be compensated at a rate of twenty five percent (25%) for accumulated unused sick leave hours. Separation from County employment under other conditions shall not qualify for payment. The employee shall have the option of trading sick leave for vacation at the rate of four (4) days of sick leave for one (1) day of vacation for sick leave accrued in excess of fifty (50) days.
 - G. Upon retirement, accumulated unused sick leave hours will be eligible upon retirement for payment at a rate of fifty percent (50%), or retiring employees may choose to apply one hundred percent (100%) of their unused sick leave towards PERS retirement credit.
- 5.7 **Vacation and Sick Leave:** Vacation and sick leave shall continue to be accrued at the normal rate while an employee remains on temporary disability and continues to supplement the benefit with sick leave and/or vacation hours. When the accrued sick leave and/or vacation hours are exhausted the employee may request a leave under Section 5.11.
- 5.8 **Family Death Leave:** The Appointing Authority shall authorize paid leave of up to five (5) days immediately following the death of a member of the employee's immediate family as defined in Article II, Section 2.23 of this MOU.
- 5.9 **Jury Duty:** The Appointing Authority shall authorize time off as needed for jury duty. If the employee transfers the fees paid for jury duty service to the County, then full pay shall be

continued during the leave. If vacation, compensatory time or other paid time off is used, the jury duty fees need not be paid to the County. Employees subpoenaed by a court of law to serve as a witness arising out of their employment with the County shall be deemed to be on duty and shall be entitled to their regular pay provided they transfer any fees for such service, exclusive of mileage, to the County. Employees who appear in court in a private matter shall not be entitled to regular pay for such service but may use vacation or compensatory leave, authorized by the Appointing Authority and consistent with Section 5.4 of this Agreement. Time off for victims of crimes shall be authorized as consistent with Section 230 of the California Labor Code.

5.10 **Military Leave:** In accordance with federal law, employees shall be entitled to military leave of absence with pay and benefits as provided in Division II, Part I, Chapter VII of the Military and Veterans Code. See the Personnel Rules for specific procedures.

5.11 **Leaves of Absence Without Pay:** Leaves of absence without pay may be granted only upon specific written request of an eligible employee, and with the approval of the Appointing Authority and the Human Resources Manager. Leaves may be granted for:

- A. Personal reasons which do not cause inconvenience to the department, not to exceed thirty (30) days in duration.
- B. Before a personal leave of absence is granted, an employee must exhaust all accrued vacation.
- C. An unpaid leave of absence may be extended up to one (1) year, upon finding of unusual or special circumstances, if recommended by the Appointing Authority and approved by the Human Resources Manager. Failure to report for duty after a leave of absence has expired, been disapproved or canceled shall be considered an automatic resignation.
- D. An unpaid leave of absence will cause a break in service, and the employee's anniversary date, evaluation date, and longevity date will be adjusted to reflect the length of time not credited to total service, except as provided under Section 5.12. An employee's seniority shall be frozen at the time of the break in service and will continue to accrue at such time as the employee returns to paid status.
- E. All paid benefits provided by this MOU will cease during the unpaid leave of absence, except as provided in Section 5.11. However, the employee has the option of continuing medical, dental and life insurance by paying the monthly premiums at group rates.
- F. The Appointing Authority may at his or her discretion approve up to five (5) days unpaid leave per calendar year to an employee for urgent or emergency absences for which the employee has insufficient accrued paid time. This time off will not be subject to approval by the Human Resources Manager and will not cause any seniority adjustment. Unpaid time off beyond the five (5) days in a calendar year is subject to all other provisions in Section 5.11.
- G. Nothing in this MOU shall restrict or enlarge leave rights provided for under the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave Act (PDL), or any other applicable State or Federal law. See Personnel Rules Manual for specific procedures.

5.12 **Family and Medical Leave:** The parties agree that County will comply fully with the statutory rights of employees under the California Family Rights Act (CFRA) and the Family Medical Leave Act (FMLA). Nothing in this paragraph waives any statutory rights of any employee. An employee with at least twelve (12) months of service, who has worked at least 1250 hours during the preceding twelve (12) month period prior to the date for which leave is taken, may be eligible to take up to twelve (12) weeks of leave in a twelve (12) month period,

defined as the twelve (12) month period measured forward from the date of an employee's first FMLA leave usage, for the birth, adoption, or placement of a foster child; leave to care for a spouse, parent or child with a serious health condition or for the employee's own serious health condition. Medical certification by a qualified health care provider shall be required for an FMLA and/or CFRA protected leave. An FMLA and/or CFRA leave will be granted as provided by law.

- A. Any absence that qualifies as an approved FMLA/CFRA leave will not be counted against an employee for purposes of determining excess sick leave usage. If a leave is FMLA/CFRA approved, no limit may be placed on the employee's option to substitute accrued vacation, sick leave or compensatory time off, floating holidays or awarded administrative days off for unpaid leave.
- B. An employee returning to work from an approved FMLA/CFRA leave is entitled to be restored to the same position of employment or an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment as provided by law. Contact Human Resources for procedural details and description on how to utilize these leave time.

- 5.13 **Pregnancy Disability Leave.** Normal pregnancy and/or complications arising from pregnancy shall be considered an illness. The County will adhere to the provisions of the California Pregnancy Disability Leave (PDL) in all situations when a woman is actually disabled by her pregnancy, childbirth, or a related medical condition. An employee may be eligible for leave of absence without pay for pregnancy disability leave of up to four (4) months regardless of whether or not said employee has used all accrued sick, vacation and paid time-off leave.

Employees disabled by pregnancy may, if eligible under the Family Medical Leave Act (FMLA) or California Family Rights Act (CFRA), be entitled to additional time off for parenting leave (aka baby bonding time) following the period of incapacity related to the pregnancy disability. Medical certification from a qualified health care provider may be required under FMLA and/or CFRA.

- 5.14 **Administrative Leave:** Where an employee has performed meritorious service, the Department Head may, in his or her discretion, grant up to three (3) days of administrative leave with pay per employee during the fiscal year. This leave shall be in addition to all other holidays and leaves available to the employee.

- 5.15 **Catastrophic Leave Program:** A Catastrophic Leave Program will be implemented by the County for any employee who has exhausted all available sick leave, compensatory time off, vacation and other paid leave. If such employee is absent from work due to their own illness or injury or that of their immediate family for a period of time anticipated to be thirty (30) days past the date of exhaustion of all paid leave, the employee shall be entitled to withdraw donations of sick leave, compensatory time off and/or vacation from other employees. Such leaves are maintained and administered by the Human Resources Department in a catastrophic leave donation time bank. The Del Norte County Sheriffs Association shall be responsible for soliciting donations to this time bank. The following conditions shall apply to donations and withdrawals:

- A. Employees may donate a maximum of five (5) days per fiscal year to the time bank from a combination of accumulated sick leave, vacation and/or compensatory time off (CTO). Donations may be made in increments of less than one (1) day, but must be in increments of two (2) hours or more. In order to donate sick leave, an employee must have not less than ten (10) days of sick leave available at the time of donation.
- B. Donated time becomes the property of the time bank and may not be recovered by the donating employee or designated for particular employee.
- C. Donated time in the bank is available to eligible employees on a "first-come, first-

serve" basis. However, two (2) employees may draw concurrently provided available resources exist.

- D. Donations must be made on a standard form circulated by and available from the Sheriffs Employees Association (SEA). All such donations are subject to verification by the Human Resources Department.
- E. The employee must exhaust all of their own accrued paid leave.
- F. The absence is anticipated to run at least thirty (30) days past the exhaustion of all paid time and shall be certified as necessary by the health care provider.
- G. Leave used from the time bank shall be considered job protected leave as required by the federal and state family and medical leave acts.
- H. Time bank records, including donation forms, time sheets, requests for withdrawal, etc., shall be maintained by the Human Resources Department.
- I. The Human Resources Department is responsible for verifying time donations and determining eligibility for use of donated time.

5.16 **Workers Compensation:** The parties agree that County will comply fully with the Workers' Compensation Code of the State of California. Nothing in this paragraph is intended to waive any statutory right of any employee. When an employee is injured on the job or becomes ill from job-related (industrial) causes, the employee is responsible for notifying his/her supervisor. The supervisor shall submit a report of the injury or illness, including date and time of occurrence and any relevant circumstances, to the Risk Manager's office. The report shall be processed in accordance with the Labor Code of the State of California and the procedures of the County workers' compensation plan.

- A. In the event a job-related (industrial) injury or illness results in time lost, the employee, with the exception of law enforcement officers who are also safety officers, shall be entitled to benefit provided under the Labor Code. This provides payment for medical treatment and hospitalization up to a maximum established by the State's benefit schedule. The employee is entitled to use accrued sick leave, compensatory time off and/or vacation time to supplement the temporary disability payments to an amount equal to, but no greater than, the employee's full salary. In the event that sick leave, compensatory time off and/or vacation time are used in this manner, they shall be charged first to sick leave, second to compensatory time off, and lastly to vacation.
- B. Vacation and sick leave shall continue to be accrued at the normal rate while the employee remains on temporary disability.

5.17 **Paid Family Leave (PFL):** The Paid Family Leave (PFL) law provides workers with a maximum of six (6) weeks of partial pay each year.

5.18 **State Disability Insurance (SDI):** All qualified employees are covered by the State Disability Insurance (SDI) plan with the sick leave integrated option, which is administered by the State of California. Qualified employees have a payroll deduction that is based on gross salary. The employee is entitled to use sick leave and/or vacation to supplement the benefit payment to an amount equal to, but no greater than, the employee's salary.

ARTICLE VI EVALUATION

- 6.1 **General Provisions:** In order to maintain a high level of service to the citizens of Del Norte County, each employee is expected to meet high standards of performance. The work performance of each employee shall be evaluated at the midpoint of the probationary period, at the conclusion of the probationary period and annually thereafter on the employee's anniversary date. A special evaluation may be prepared by the employee's appointing authority at any time when warranted by either outstanding work performance, or when work performance is unsatisfactory. In addition, a special evaluation will be prepared by an employee's appointing authority at an employee's written request, but no more frequently than once between annual evaluations. In addition, the Human Resources Manager may request a report from the appointing authority on the overall performance of any employee, at any time.
- A. All evaluation documents shall become a permanent part of the employee's personnel file.
 - B. It shall be the duty of each appointing authority during the probationary period of each employee in the department to investigate thoroughly the probationer's adjustment, performance and general acceptability, and to keep the probationer advised of his/her progress and to determine whether or not the probationer is fully qualified for permanent appointment. At least fifteen (15) working days prior to the completion of the probationary period, the appointing authority shall submit a completed evaluation form to the Human Resources Manager and provide a copy to the employee.
 - C. Alleged violations of this Section are subject to the grievance procedure contained in Article XI of this MOU. However, disputes over the ratings and comments on an employee's evaluation shall not be subject to mediation. Employees are not entitled to representation at the initial evaluation meeting with the supervisor.
 - D. No complaint against an employee may be referred to in an evaluation unless the employee has been made aware of the details of the complaint within thirty (30) days that the County became aware of the complaint.
 - E. The employee shall have the right to file a response within ten working days of receipt of the evaluation, including any attachments, witness statements, or the like. The response shall be attached to any copy of the evaluation maintained by the County.
- 6.2 **Performance Improvement Plan:** The appointing authority or Human Resources Manager may request a performance improvement plan be prepared to provide clear direction to an employee whose performance is substandard.
- 6.3 **Probationary Period:** All employees in permanent positions shall be subject to a probationary period. A probationary period will commence upon the effective date of hire into a permanent position, including promotion. Service prior to a permanent appointment shall, upon recommendation of the department head and approval by the Human Resources Manager, be counted as part of the probationary period, providing the temporary or provisional continuous service was in the same class as the position to which the probationary appointment is made. The regular probationary period shall be six (6) months. The probationary period for employees in the classifications of Deputy Sheriff, Sergeant, Detective Sergeant, Sheriff's Detective, Senior Dispatcher, Dispatcher, Correctional Sergeant, Correctional Officer and Bailiff Sergeant, shall be twelve (12) months. An employee attains permanent status upon successful completion of the prescribed probationary period, and execution of the appropriate personnel action form. An employee who will not attain permanent status shall be provided a notice of probationary termination at least fifteen (15) working days prior to the conclusion of the probationary period.
- 6.4 **Extension of Probationary Period:** The appointing authority may request an extension of the

probationary period up to a total of six (6) additional months for an employee. Written extension requests are to be submitted for review to the Human Resources Manager at least fifteen (15) working days prior to the end of the probationary period. The request shall contain the reasons and justification for the extension, and the duration of the extension requested. The request shall be accompanied by an employee's performance report and, when required by the Human Resources Manager, a performance improvement plan. If approved by the Human Resources Manager, the employee shall be notified in writing by his/her appointing authority of the extension of his/her probationary period and the specific reasons for the extension. An employee attains permanent status upon successful completion of the probationary period, and execution of the appropriate personnel action form.

- 6.5. **Probationary Service:** A newly-hired employee is subject to separation from County service at any time during the prescribed probationary period, without right of appeal or hearing, except as may otherwise be provided by law. In case of a probationary termination, the appointing authority shall notify the probationary employee in writing of the fact that s/he is being separated from County service. Notice shall be provided at least fifteen (15) working days prior to the end of the probationary period. In the case of a promoted employee who fails to complete the probationary period following promotion, every reasonable attempt will be made to reinstate the employee to his/her previous position, provided that said position is open.
- 6.6. **Mid-Term Review:** After completion of three (3) months of a six (6) month or six (6) months of a twelve (12) month probationary period, an appointing authority may initiate a performance evaluation. The appointing authority may conclude the probationary period if the performance is above satisfactory. This action is subject to approval by the Human Resources Manager.
- 6.7 **Departmental Personnel File:** An employee shall be given a copy of their departmental personnel files upon the employee's written request within ten (10) working days.

ARTICLE VII

TRANSFER, PROMOTION, REASSIGNMENT AND VOLUNTARY DEMOTION

- 7.1. **Effect of Lateral Transfer:** A permanent employee who is transferred laterally, whether in the same department or to a different department, continues to be a permanent employee and does not have to serve a new probationary period in the new position. A probationary employee who is transferred laterally must serve a new probationary period in the new position. A transferred permanent employee retains all of the seniority accrued in the earlier position(s), but the employee's anniversary date shall be changed to reflect the date of assignment to the new position. A transferred permanent employee retains the same salary step placement, including longevity, received in the former position.
- 7.2. **Effect of Promotion:** An employee who is promoted, whether in the same department or to a different department, must serve a probationary period in the new position. The employee receives a new anniversary date upon promotion. A promoted employee shall be placed at the lowest step of the new salary range which provides for a minimum 5% increase in salary. A promoted employee on step F, G, H, or I will remain at their longevity step in the new range.
- 7.3. **Voluntary Demotion:** An employee may be demoted to a vacant position in a lower class, or to a lower level in the same class series, either in the same department or a different department, upon the employee's written request and with the approval of the appointing authority and the Human Resources Manager. This action shall be known as a voluntary demotion and shall be noted on all official records.
- 7.4. **Effect of Demotion and Demotional Transfer:** An employee who is demoted, either voluntarily or involuntarily, shall be treated as follows:
- A. If the employee is probationary and remains in the same department, his/her probationary period shall be a continuation of the probationary period being served at the higher level.
 - B. If the employee is permanent and remains in the same department, s/he shall not be required to serve a new probationary period in the next lower class.
 - C. If the employee, probationary or permanent, is appointed to a different department, the appointing authority may require the employee to serve a full probationary period.
 - D. If the employee is returned to a former class in which the employee held permanence, whether in the same or a different department, the employee shall not be required to serve a new probationary period.
 - E. The employee receiving a demotion shall be placed at a step in the new salary range which provides for the least loss of pay, but shall be placed on step F, G, H, or I if that step was held in the former position.
- 7.5. **Class Series Advancement:** Employees may move upward in a class series upon the recommendation of the appointing authority, and with approval of the Human Resources Manager, when the following criteria are met:
- A. The employee's qualifications must satisfy the qualifications indicated on the job description in the area of experience, and work performance must be rated above satisfactory.
 - B. In addition to the above, advancement to a III level requires that the employee provide

lead person duties or be the only clerical employee who is responsible for all clerical functions in the department or unit.

C. An employee who receives a class series advancement shall serve a new probationary period.

7.6. **Grant Positions:** When a grant position is made a regular County position by action of the Board of Supervisors, the individual occupying that position may be appointed to that position by the appointing authority and with the approval of the Human Resources Manager, without normal recruitment procedures.

7.7. **Reassignment:** Employees may, from time to time, be affected by reorganization of their department, change of assigned worksite of their employment unit, or other factors which result in the physical relocation of the employees' worksites or work stations within the department. In all such cases, employees shall be reassigned to the new worksites or work.

ARTICLE VIII
CLASSIFICATION AND RECLASSIFICATION

- 8.1. **General Provisions:** When the County classifies new permanent positions or reclassifies existing permanent positions, the County will notify the Association of the compensation level proposed to be paid. The Association may exercise its right to meet and discuss on the level of compensation by notifying the County to that effect prior to action being taken.

ARTICLE IX HEALTH & WELFARE BENEFITS

- 9.1. **Eligibility for Insurance Benefits:** All permanent, probationary and provisional employees are eligible for insurance benefits, subject to annual deductibles and copays. Extra help, part time, limited term, temporary and seasonal employees shall receive only those fringe benefits required by law. Employees entitled to health benefits shall be eligible for coverage following completion of sixty (60) days of active employment in an eligible status. All employees shall contribute the Mandatory Health Insurance Contribution, equivalent to five percent (5%) of their gross biweekly salary through payroll deduction as the employee portion of the health plan premium. The employee shall continue to be responsible for their five percent (5%) contribution during any period of an authorized absence based on the employee's current grade and step. In addition, the employee may elect to cover dependents by the payment of premiums through payroll deduction. See the Health Care Plan Booklet contained in Appendix B for specific benefits, co-pays and continuation coverage provisions. During the term of this Agreement, the parties may, by mutual agreement, modify health care and other insurance options.
- 9.2. **Dependent Coverage Rates:** Eligible employees may enroll dependents by payment of premiums through payroll deduction. Dependents include legal spouses and registered domestic partners, and children. For specific dependent coverage rate information, refer to Appendix C. The employee shall continue to be responsible for the payment of dependent premiums during any period of an authorized absence.
- 9.3. **Health Benefits:** The County provides health benefits under its health plan, a copy of which is attached to this MOU as an exhibit. See the Health Care Plan Booklet contained in Attachment B for specific benefits, co-pays and continuation coverage provisions.
- 9.4. **Plan Continuation Benefit:**
- A. Employees who retire from County service may continue their medical coverage at County group rates at their option, and subject to all rules and regulations of the County's medical benefits carrier at the time. It is understood and agreed that the County shall not be liable for payment of any premium to the medical carrier. If the retired employee fails for any reason to make a payment when due, the County will not make the payment for him/her, and the benefit could be lost in this event.
 - B. Employees retiring after serving a minimum of twenty (20) years in Del Norte County service shall be eligible for County paid health care coverage after attaining the age of fifty (50) at no cost to the retiree until the retiree qualifies for Medicare benefits. For specific retiree rates, including dependent coverage rates, refer to Appendix C.
 - C. Employees and their eligible dependents shall be notified of their rights (if any) to continue health care benefit coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
 - D. Effective November 1, 2009, employees hired after November 1, 2009 shall not be eligible to continue health insurance coverage as a retiree until they have achieved fifteen years continuous county service. Employees hired between January 1, 2007 and October 31, 2009 shall not be eligible to continue health insurance coverage as a retiree until they have achieved ten year continuous county service. All employees hired prior to January 1, 2007 shall be unaffected by this article.
- 9.5. **Premium Conversion Plan:** The County makes available to employees a premium conversion

plan under Internal Revenue Code Section 125, by which employees who pay for dependent medical care may have their premium contributions paid with pre-tax dollars.

- 9.6. **Life Insurance:** The County provides a life insurance policy of twenty five thousand (\$25,000) at no cost to the employee. Mid-management/professional and confidential employees are provided a life insurance policy equal to one (1) year gross pay at no cost to the individual.
- 9.7. **Voluntary Insurance Plans:** Employees are eligible for a variety of employee and dependent paid insurance plans offered through AFLAC. Voluntary insurance plans are paid for by the employee through payroll deduction of premiums, at no cost to the County.
- 9.8. **Ground and Air Ambulance Plan:** The County shall provide memberships for all employees in Del Norte Ambulance, Cal-Ore Life Flight and Mercy Flights ambulance plans. This plan shall be provided to permanent employees upon completion of two (2) months continuous service and their insured family members.
- 9.9. **Vision Plan:** The County shall provide vision coverage to all SEA represented employees effective upon completion of two (2) months of continuous service. For specific plan benefits and deductible information, please refer to the coverage documents provided to all employees at time of hire.
- 9.10 **PERS Employee Contribution:**

A. **Miscellaneous New Members:** Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), employees hired after January 1, 2013 defined as "New" miscellaneous employees shall pay the member contribution established under PEPRA. Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), effective the first full pay period in July 2018, employees shall pay a total of eight percent (8%). Should this rate established by CalPERS fluctuate during the term of this Agreement, the employees will pay the established rate. At no point shall "New" members pay a contribution rate that is less than the Classic members.

B. **Safety New Members:** Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), employees hired after January 1, 2013 defined as "New" safety employees shall pay the member contribution established under PEPRA. Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), effective the first full pay period in July 2018, employees shall pay a total of twelve percent (12%). Should this rate established by CalPERS fluctuate during the term of this Agreement, the "New" employees will pay the established rate. At no point shall "New" members pay a contribution that is less than the Classic members.

The County shall take all required action to designate the classification of correctional sergeant and correctional officer covered under this agreement as eligible/covered for safety retirement under the PEPRA 2.7% at 57 formula effective the first full pay period in July 2018.

C. **Miscellaneous Classic Members:** Effective with the adoption of this Agreement, all classic vested and non-vested employees shall continue to pay the member contribution of six and one quarter percent (6.25%). Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), effective the first full pay period in July 2018, employees shall pay a total of eight percent (8%).

D. **Safety Classic Members:** Effective with the adoption of this Agreement, all classic vested and non-vested employees will each continue to pay the member contribution

of eight and one quarter percent (8.25%). Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), effective the first full pay period in July 2018, employees shall pay a total of twelve percent (12%).

- 9.11. **PERS Benefit Calculation:** Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), the benefit calculation for employees hired after January 1, 2013 who are not transferred from a CalPERS or CalPERS reciprocal agency or have a break in service of six (6) months or longer shall be the thirty-six (36) highest consecutive months final compensation provision using the 2.7% @ 57 formula for Safety Employees and the 2% @ 62 formula for Miscellaneous Employees.

For employees hired prior to January 1, 2013, or Classic Employees, the benefit calculation shall be based on the twelve (12) highest paid consecutive months using the 2% @ 50 formula for Safety Employees and the 2% @ 55 formula for Miscellaneous Employees.

- 9.12. **Rain Gear:** The County provides appropriate rain gear for all employees whose work locations are not protected from the weather. The County is not required to provide rain gear to individual employees. The County makes this gear available to qualified groups of employees.

- 9.13. **Uniform/Equipment Allowance:** Uniform allowance shall be paid to Deputies, Sergeants, Correctional Officers, and any other classification required to maintain a uniform as follows.

- Two hundred fifty dollar (\$250.00) allotment payable the first pay period of the fiscal for those hired prior to July 1 or each year.
- Thirty dollars (\$30.00) biweekly.
- Newly hired employees shall receive five hundred dollars (\$500.00) on their first payday following their hire date to offset the initial cost of uniform and safety equipment in addition to the biweekly allowance.
- Uniform/equipment allowance shall not be subject to prorating based upon hire or separation dates.

A. **Uniform Modification:** Modifications to the uniform are a meet and confer item.

- 9.14. **Employee Discount Program:** The County will participate in and pass along employee discounts offered by vendors as they become available, provided said participation does not violate legal or ethical rules. Participation in such discount programs shall not hold the County liable in any manner. Offers or programs that require County staff time to verify employment or in any way assist in the overall management of the discount program shall be considered on a case by case basis. Examples of employee discount programs are, but not limited to the following: Microsoft Office software purchase, Verizon Wireless discount, and Dell computer purchasing program. Specific information regarding current discount programs may be obtained from the Human Resources Office.

- 9.15. **Gym Membership Program:** The County shall offer a gym membership program to SEA represented employees. The following guidelines shall apply:

- A. Employees must attend the gym a minimum of ten (10) times per month.
- B. The employee shall pay the magnetic card deposit of \$10.00, which is refundable.
- C. If the attendance criteria are not met, the monthly membership fee shall be deducted from the affected employee's paycheck during the following pay period.
- D. Employees shall submit a usage report from the gym for the previous month to the Sheriff's Department fiscal staff no later than the fifth (5th) day of the following month in order to be eligible.

- E. In the case of authorized absence (injury, illness or vacation) that has caused the employee not to meet the attendance criteria, the employee shall submit a memo justifying the lack of attendance to the Sheriff for adjudication no later than the 5th day of the following month. Appeals of any decision made by the Sheriff regarding eligibility shall be subject to the grievance process in Article XI of this MOU.
- F. Time spent at the gym shall not be considered work time and any injury or illness arising from use of the gym shall not be the responsibility of the County except as otherwise provided by law.
- G. If an employee fails to meet the criteria of attending a minimum of ten (10) times per month without approval from the Sheriff three (3) times during a fiscal year, the employee shall be suspended from the program for a period of six (6) months.

ARTICLE X LAYOFF AND REEMPLOYMENT

- 10.1. **Reason for Layoff:** Whenever, in the judgment of the Board of Supervisors, it becomes necessary to reduce County staffing levels, positions may be abolished and employees may be laid off, including those employees who have been granted an approved leave of absence. The order in which employees would be separated or demoted in a reduction in force shall be based upon type of appointment, seniority and to the extent practical, relative efficiency. The Human Resources Office shall notify each employee who is to be laid off, and the Association, in writing not less than fourteen (14) calendar days prior to the effective date of layoff. During the fourteen (14) day notice period, up to forty (40) hours may be granted to each employee being laid off to be away from work for job search purposes.
- 10.2. **Area of Layoff:** The classes and geographic areas of layoff are to be determined by the Appointing Authority in the affected department, subject to concurrence by the Human Resources Manager. Employees laid off in designated programs or geographic areas of a department shall have the right to displace employees in other programs or geographic areas of the department who are lower on the seniority list as determined by the Human Resources Manager.
- 10.3. **Retirement In Lieu:** Any eligible employee may accept a service retirement in lieu of layoff. An employee who chooses to retire shall inform the Human Resources Office in writing not less than ten (10) days prior to the effective date of layoff. The County shall assist the employee with processing retirement through PERS. An employee who retires in lieu of layoff shall be placed on the one year reemployment list along with other laid off employees. The employee's eligibility for retirement shall be governed by applicable statutes and the regulations of PERS. The County agrees that, when an eligible retiree responds positively and in a timely fashion to an offer of reemployment, the retiree shall be granted the time necessary to terminate retired status and return to active employment. An eligible retiree who declines a reemployment offer in the class and department from which laid off shall be removed from the reemployment list and be considered permanently retired.
- 10.4. **Seniority Score Computation:**
- A. Persons with permanent or probationary appointments with the County shall receive credit for all employment in County departments provided that employment has been in continuous service. Persons hired from a reemployment list regain all previously earned seniority on the date of reemployment.
 - B. Employees on approved leaves of absence such as educational leave, military leave, maternity leave and disability leave shall retain seniority accumulated before the leave of absence. The time on such approved leave of absence is not included in the seniority score computation. Time on industrial disability leave shall be included in the seniority score computation.
 - C. One point seniority credit shall be given for each qualifying month of service.
 - D. Nothing in this provision shall preclude the seniority policy established in Article III of this MOU.
 - E. Twelve points shall be added to the seniority score of an employee with an overall rating of exceptional, with a rating of five (5) or similar term denoting exceptional in the highest rating category in the performance appraisal system, on the last two regularly scheduled written performance evaluations.

- 10.5. **Qualifying Month of Service:**
- A. When computing seniority for full-time employees, the starting and ending months of a period of service shall be considered a complete month if the employee has fifteen (15) or more calendar days of service. No credit is given for less than fifteen (15) days of service.
 - B. In order to receive a seniority point for an appropriate month, an employee must be considered in an "in-pay" status for fifteen (15) or more calendar days.
 - C. For other than full-time employees, 160 hours worked shall be equivalent to one month's service and seniority credit shall be given upon the completion of each 160 hours worked.
- 10.6. **Equal Seniority:** If two employees in the class in the department have the same seniority score, the County and the Association shall meet and confer to determine which employee has the greatest seniority.
- 10.7. **Temporary Positions:** No employee serving in a temporary extra-help or limited term position shall be retained if employee(s) in the same class in the department are being laid off. No temporary employee may be hired into a class in a department while permanent employees are on a reemployment list for the same class in the department. Employees on the reemployment list shall have priority for temporary positions.
- 10.8. **Notice of Reduction in Force:** The Human Resources Office shall send written notice to each employee affected by a reduction in force at least fourteen (14) calendar days prior to the effective date of the action. The notice shall include:
- A. Reason for layoff;
 - B. Classifications to which the employee has retreat rights to under section 10.5;
 - C. Effective date of the action;
 - D. Seniority score of the employee;
 - E. Location of the seniority list so that employees may compare their scores with others
 - F. Conditions governing retention on and reinstatement from reemployment lists;
 - G. Rules regarding waiver of reinstatement and voluntary withdrawal from the reemployment list.
- 10.9. **Retreat Rights:** An employee to be laid off from his/her position may elect to displace the least senior employee in the class in the department. If there is no less senior employee, the employee may displace the least senior employee in the department in a lower class in which the employee to be laid off has served in a permanent status, if the employee to be laid off has more seniority than that employee in the lower class. An employee displaced by a more senior employee may likewise exercise retreat rights within the department, in order of seniority. An employee displaced by a more senior employee exercising retreat rights has the same reemployment rights as an employee who is laid off. An employee who is to be laid off who chooses to exercise retreat rights must inform the Human Resources Office of that decision in writing within five (5) working days of receipt of the notice of layoff. Employees who exercise retreat rights shall not be required to serve a probationary period in the class they retreat to.
- A. An employee who retreats to a lower class in the department shall be placed at a step of the appropriate salary range which represents the least loss of pay. An employee may not be advanced to a longevity step (F, G, H, or I) unless longevity has already been attained.

- B. Employees retreating to a lower classification shall serve a probationary period in the new classification unless they have previously successfully completed a probationary period in the classification.
- 10.10. **Reemployment Rights:** Laid off employees, and employees displaced from their positions by more senior employees, shall be eligible for reemployment in the class held at the time of layoff for a period of eighteen months from the effective date of layoff or displacement. Reemployment shall be in the reverse order of layoff. Their reemployment shall take precedence over hiring and transfers when a vacancy in the class of former placement comes available in the same department.
- A. Employees on a reemployment list shall have the same rights as active employees to seek transfers and promotions to vacant positions in other classes throughout the County.
- B. An employee who is reemployed in the same class from which laid off or displaced during the one year life of reemployment rights, whether in the same or a different department, shall be restored to the same salary step held at the time of layoff or displacement. If the employee exercised retreat rights to a lower class at the time of layoff, salary step placement shall be adjusted upward upon reemployment as if the employee had served that time in the original class. The time on the reemployment list shall not be considered a break in service, except that the employee's original hire and anniversary dates shall be adjusted to deduct the time off work.
- C. The names of persons laid off or demoted shall be entered upon reemployment lists for positions for which they are qualified. Lists from different departments or at different times for the same class shall be combined into a single list. These lists shall be used by every appointing authority when a vacancy arises in the same or lower classes before certification is made for an eligibility list.
- 10.11. **Reemployment Notice:** Whenever there is an active reemployment list, the County shall provide written notification of appropriate openings to employees on the list by first class mail, addressed to the employee's last known address. It is the employee's responsibility to keep the County currently informed of his/her mailing address. The County's responsibility to provide notice under this Section is waived if a notice is returned to the County as undeliverable.
- 10.12. **Employee Response:** A laid off/displaced employee who accepts a reemployment offer is responsible for notifying the Human Resources Office of acceptance in writing within five (5) days of receipt of a reemployment notice. An employee accepting reemployment shall return to duty not later than thirty (30) calendar days following the date of intended reemployment announced by the Human Resources Office. The employee is responsible for notifying the Human Resources Office in writing of the time needed to return to duty.
- 10.13. **Wage, Hour and Working Condition Issues:** The County and the Association recognize that layoffs and displacements may trigger problems among remaining employees in a department in such areas as distribution of the work of laid off employees, preservation of bargaining unit work within the unit, classification levels of remaining employees, workload and work scheduling problems, and similar issues. It is agreed that these issues will be addressed on a case-by-case basis, upon receipt by the County of a request to meet and confer from the Association.

ARTICLE XI GRIEVANCE PROCEDURE

- 11.1. **Purpose:** It is the purpose of this procedure to provide an avenue of communication through which an employee or groups of employees may have their complaint heard and decided in an orderly and timely manner.
- 11.2. **Definition of a Grievance:** A grievance is a complaint of an employee or group of employees alleging the violation, misinterpretation or misapplication of any provision of this Memorandum of Understanding, or working conditions within the control of the department head, including rules and regulations, and disciplinary action for which no other procedure for orderly adjudication of the complaint exists.
- 11.3. **Definition of a Grievant:** A grievant is any employee within the bargaining unit represented by the Association alleging a grievance.
- 11.4. **Timeline for Filing a Grievance:** A grievance must be filed within thirty (30) calendar days after the event, or the grievant becomes knowledgeable of the event, but in no case after sixty (60) days of the event. This time limit includes the informal procedure. Time periods set forth in the grievance procedure may be extended by mutual written agreement of the County and the grievant, or the County and the Association, if the Association is representing the grievant.
- 11.5. **Informal Grievance Procedure (Step One):** Any employee, or group of employees, shall first discuss their grievance with the immediate supervisor. If not resolved within three (3) regular working/business days, the employee shall contact the department head. If, within five (5) regular working/business days, the department head has not resolved the grievance to the satisfaction of the employee, the employee may submit his/her grievance in writing pursuant to the following procedure.
- 11.6. **Formal Grievance Procedure (Step Two):** The grievant may submit a formal grievance in writing on the form provided by the Human Resources Office. Within ten (10) regular working days of receipt of the grievance, the Human Resources Manager shall investigate and provide a response in writing to the grievant. The response shall include a complete statement of the supervisor's position and facts and evidence upon which it is based, and the remedy or correction which has been offered, if any. The grievance form, and any requests for hearing shall be in writing and set forth the specific provision(s) of the MOU the grievant alleges to have been violated, misinterpreted, or misapplied, and shall set forth facts supporting the allegations and the resolution desired.
- 11.7. **Step Three:** If within five (5) regular working/business days of receipt of the Human Resource Manager's written response, the grievant disputes the resolution proposed, the grievant may request that the grievance be heard before a mediator of the California Mediation and Conciliation Service. The request shall be in writing or on a form provided by the County stating the reasons why the proposed resolution is still disputed. The outcome of this mediation shall be advisory in nature.
- 11.8. **Step Four:** If, within five (5) regular/working business days of receipt of the response of the mediator, the grievant disputes the proposed resolution, the grievant may request that the grievance be heard before the Board of Supervisors of the County of Del Norte. The request shall be in writing or on a form provided by the County stating the reasons why the outcome is still in dispute. The requested hearing must be held within twenty (20) regular/working days of receipt of the appeal by the Clerk to the Board. The Board's decision shall be in writing, stating

the reasons for their decision and shall be presented to the grievant within five (5) regular/working days of the hearing. The decision of the Board of Supervisors shall be final.

- 11.9. **Performance Standards:** Employees who file grievance are not excused from performing their jobs to acceptable standards at all times during the processing of a grievance.
- 11.10. **Representation Rights:** The Association shall have the right to represent employees in the bargaining unit in grievances. Individual employees may process their own grievances without assistance from the Association up to and including the Board of Supervisors level. The Association has no obligation to represent any employee's grievance once the employee has filed a formal written grievance without Association representation.
- 11.11. **Employee Processed Grievances:** The County agrees to provide the Association with a copy of the proposed resolution(s) to any grievances processed by employees without Association representation, except those grievances containing a confidential component. The Association shall be granted five (5) regular work/business days to review the proposed resolution(s) prior to implementation, to determine that the proposed resolution(s) are in conformance with the terms of this MOU.
- 11.12. **Release time for Witnesses:** The County agrees to release from duty without loss of pay or benefits any employee called as a witness in any grievance by the Association or an individual employee grievant.

ARTICLE XII DISCIPLINE

- 12.1. **General Provisions:** Employees may be disciplined only in accordance with the provisions of this Article.
- 12.2. **Discipline:** Discipline means all personnel actions resulting from acts or omissions on the part of an employee consisting of written warnings, written reprimands, suspension without pay, demotion or dismissal. Permanent employees shall be disciplined only for just cause. All reasonable efforts shall be made to apply discipline progressively, to afford the employee a reasonable opportunity to correct deficient work practices or conduct. Newly-hired probationary employees may be suspended without pay, demoted or dismissed without the right to appeal or hearing. Promotional probationary employees who have previously achieved permanence in any class enjoy full due process rights established in this Article and in Section 6.5 of this MOU.
- A. Written warnings and written reprimands may be challenged through the grievance procedure contained in Article XI of this MOU. However, these disputes shall not be subject to a hearing under Article XI.
- B. Discipline may not be imposed on a permanent employee for any cause of which the County had knowledge for which discipline was not imposed and which occurred more than six (6) months prior to the issuance of formal charges.
- 12.3. **Right to Representation:** Whenever disciplinary action is initiated by the appointing authority, the employee shall be advised that s/he has a right to the presence of a representative, including the Association, at all stages of the proceedings, including, but not limited to, discussions and interrogations involving the employee, and at informal and formal disciplinary hearings.
- 12.4. **Clearance for Disciplinary Action:** Any proposed disciplinary action shall be approved by the Human Resources Manager prior to any action being taken, in order to insure conformity with the procedures established in this Article, and consistency in the severity of discipline applied.
- 12.5. **Leave Pending Investigation:** Only on approval of the Human Resources Manager may an employee against whom charges have been served pursuant to Section 12.14, or who is under investigation for possible discipline, be placed on paid administrative leave pending an investigation. Such time shall be granted with pay and without prejudice as to the alleged violation.
- 12.6. **Negative Evaluations:** A negative evaluation shall not of itself constitute grounds for discipline of a permanent employee. However, the deficiencies in employee performance including conduct documented in a negative evaluation may constitute grounds for discipline, and may result in charges being brought against an employee under the provisions of this Article.
- 12.7. **Disciplinary Documents:** All documents pertaining to a disciplinary action shall become a permanent part of the employee's personnel file.
- 12.8. **Performance Improvement Plan:** A performance improvement plan is required as a part of a written warning, written reprimand, suspension without pay or demotion. The corrective action plan, along with any disciplinary documents, shall become a permanent part of the employee's personnel file. The corrective action plan shall be prepared by the appointing authority and be subject to the approval of the Human Resources Manager prior to delivery to the employee.

- A. A performance improvement plan shall identify and describe the problem to be solved; the specific training and/or instruction program necessary to resolve the problem; a time frame in which the problem is to be resolved, and; a description of consequences of failing to abide by the correction action plan, failure to improve, or repeating the same violation within the time frame of the plan. A performance improvement plan may become a basis for progressive discipline if the violation or act that generated the corrective action is repeated.
- 12.9. **Grievability:** The allegations, contents and outcomes of disciplinary actions are not grievable. However, alleged procedural violations of this Article shall be raised as part of the disciplinary proceedings rather than under the grievance procedure set forth in Article XI.
- 12.10. **Grounds for Disciplinary Action:** The following constitute grounds for disciplinary action:
- A. Conviction of a felony.
 - B. Misappropriation of County funds or property.
 - C. Misconduct.
 - D. Intentional or neglectful misuse of County property resulting in increased maintenance or repair costs or a reduction in service life of the equipment.
 - E. Use of County property not related to job function or for personal gain.
 - F. Failure to improve substandard performance.
 - G. Discourteous, discriminatory, offensive or abusive treatment of the public or fellow employees.
 - H. Drinking alcoholic beverages or use of controlled substances without a prescription on the job, or arriving on the job under the influence of alcohol or controlled substances without a prescription.
 - I. Habitual absenteeism or tardiness.
 - J. Absence without notification.
 - K. Abuse of sick leave or any other paid leave.
 - L. Disorderly conduct.
 - M. Incompetence or inefficiency in the performance of assigned duties.
 - N. Being wasteful of material, property or working time.
 - O. Insubordination, including, but not limited to, refusal to perform assigned tasks.
 - P. Violation of any lawful, safe and reasonable order or written regulation made or given by an employee's supervisor or higher County authority.
 - Q. Neglect of duty.
 - R. Dishonesty.
 - S. Fraud in securing employment.
 - T. Gross misconduct.
 - U. Refusal or failure to comply with safety rules and/or regulations, including drug and alcohol policies, promulgated by any government agency with jurisdiction.
 - V. Refusal to take a medical examination required by the County.
 - W. Serious physical and/or mental disability which prevents the employee from performing the essential functions of the position, even with reasonable accommodation of the disability.
 - X. Failure to maintain any formal licensing or certification required for the employee's position.
 - Y. Falsification of County records.
 - Z. A violation of another person's constitutional rights.

- AA. Knowing and intentional disclosure of information which is confidential by law or written departmental policy.
 - BB. Engaging in threats or violence, direct, indirect, implied or actual, against co-workers or any other person in connection with County business.
- 12.11. **Disciplinary Procedure:** Discipline may be imposed for the violation of any provision of Section 12.10. A written warning may be given for the first or a relatively minor violation, and shall set forth the particular violation and a corrective action plan. A written reprimand may be given for repeated violations or a violation of increased severity, and shall set forth the particular violation(s) and a corrective action plan.
- 12.12. **Written Notice of Charges:** When the appointing authority determines that sufficient grounds exist for imposing discipline on an employee, and following clearance by the Human Resources Manager, the appointing authority shall prepare and provide to the employee a written notice of charges at least five (5) working days prior to the effective date of the proposed discipline. The notice shall contain the following information:
- A. The provision(s) of Section 12.10 allegedly violated.
 - B. A statement of the specific acts or omissions upon which the discipline is based, including the names, dates, times, locations and circumstances of the alleged violation(s), unless the information is privileged, stated in clear and concise language. The statement shall be sufficiently specific as to fully inform the employee of the nature of the charges against him/her.
 - C. A statement that a copy of all non-privileged materials upon which the discipline is based are attached or available for inspection upon request.
 - D. A description of the proposed discipline and its effective date(s).
 - E. A statement advising the employee of the right to request a hearing on the charges, and the time frame in which such a request must be made.
 - F. A statement advising the employee of the right to representation at any and all disciplinary proceedings.
 - G. A blank "Response to Charges and Request for Hearing" form, the signing and return of which to the Human Resources Manager constitutes activation of the hearing process.
- 12.13. **Service of Charges:** All notices of proposed discipline shall be personally served upon the employee, or mailed by certified mail, return receipt requested, to the last known address of the employee.
- 12.14. **Employee Response:** The employee may deny all of the charges and request a hearing on the charges by delivering a written statement which includes the grounds for denial of the charges to the Human Resources Manager within five (5) regular working/business days of the date of receipt of the charges. This statement may be made on the form provided for that purpose along with the charges, or on a separate piece of paper, signed and dated by the employee.
- 12.15. **Failure to Respond:** If the employee fails to request a hearing within five (5) regular working/business days of receipt of the charges, the right to a hearing is waived, and the appointing authority may impose discipline upon the employee, with the approval of the Human Resources Manager.
- 12.16. **Informal (Skelly) Hearing:** If the employee requests a hearing on the charges, the Human Resources Manager shall schedule an information hearing at which the employee may answer and refute the charges, present mitigating evidence or otherwise respond to the charges. The Human Resources Manager shall issue an opinion and decision within ten (10) regular working/business

days of the hearing. If the Human Resources Manager upholds the charges a formal hearing shall be scheduled, unless the employee withdraws the request for hearing at that point. If the Human Resources Manager finds that the discipline proposed is not justified, the Human Resources Manager may order the charges rejected and the employee exonerated with full salary and benefits. The Human Resources Manager may also reduce the severity of discipline proposed. If this occurs, the employee may still choose to go forward to a formal hearing on the charges. It is the intent of the parties that all disputes be resolved at the lowest administrative level possible.

- 12.17. **Formal Hearing:** If the employee is dissatisfied with the Human Resources Manager's decision, the employee must notify the Human Resources Manager within ten (10) days after the Human Resources Manager's decision has been mailed or delivered to the employee. The Human Resources Manager shall arrange for a formal hearing on the charges. The Association and County may agree to a hearing officer; if they do not, they shall select an arbitrator as provided below:

A. The parties may agree to an arbitrator. If they cannot agree on selection of the arbitrator, they shall make a joint request to the State Conciliation Service for a list of five (5) qualified arbitrators. The arbitrator shall be selected from the list by alternatively striking names, with the opportunity to go first decided by chance.

B. The parties shall submit briefs and documents to the arbitrator at least ten (10) days before the hearing.

C. The arbitrator shall not be empowered to alter, amend, change, add to or subtract from any terms of this MOU. The decision of the arbitrator shall be based solely upon the evidence and arguments presented by the parties to the arbitration. The decision shall be final and binding upon the parties.

D. Each party shall bear its own witness and/or attorney fees. Because of the impact of *Florio v. City of Ontario*, (05 CDOS 6192), in cases where the hearing arises directly from imposed or proposed discipline against the grievant, County shall bear the entire cost of the arbitration, but parties shall continue to bear their own attorney's fees and/or witness fees.

- 12.18. **Conduct of Hearing:** The employee may request either an open or closed hearing at his/her discretion. The technical rules of evidence shall not apply, but oral testimony shall be taken only on oath or affirmation. Any relevant evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of this evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but shall not be sufficient to support a finding unless it would be admissible over objection in civil actions. The rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the hearing, and irrelevant and unduly repetitious evidence shall be excluded.

A. Each party shall have these right: to call and examine witnesses; to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though the matter was not covered in the direct examination; to impeach any witness regardless of which party first called him/her to testify; and to rebut the evidence against him. If the employee does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

B. The County shall open the case and present evidence in support of the discipline proposed. The County shall have the burden of proving charges by a preponderance of the evidence.

C. Relevant documents which are part of the employee's personnel file, and those constituting the disciplinary action being appealed and upon which the County

intends to rely in presenting its case, may be admitted as evidence in the hearing.

- D. The employee may present his/her case in person or through a representative of his/her choice.
 - E. The hearing shall be recorded verbatim by a court reporter who shall be compensated by the County. The costs of any transcript ordered shall be borne by the party ordering the transcript.
 - F. The costs of the hearing officer shall normally be borne by the County. However, if the County believes the employee's defense of the charges is frivolous and without merit, the County may raise a frivolous defense claim at the hearing. If the hearing officer rules that the employee's defense was frivolous and without merit, the costs of the hearing officer shall be borne by the employee.
 - G. The decision of the hearing officer shall be final and shall be submitted within ten (10) days. The arbitrator shall issue a finding on each charge and specification individually, and on the charges as a whole. The decision shall be final and binding on the parties.
- 12.19. **Proposed Decision:** After the close of the hearing, the hearing officer shall submit his/her proposed decision in writing as promptly as possible simultaneously to the employee or his/her representative and to the Human Resources Manager no later than ten (10) working days after the hearing. The arbitrator shall issue a finding on each charge and specification individually, and on the charges as a whole. The hearing officer shall also recommend discipline appropriate to the findings.
- 12.20. **Board of Supervisors Action:** The proposed decision shall be submitted to the Board of Supervisors at the next regularly scheduled Board meeting. The Board of Supervisors may adopt the decision in whole, amend it, reject it, or impose discipline different than that recommended by the hearing officer. However, the Board may not impose discipline greater than that recommended by the Human Resources Manager following the information hearing. If the Board of Supervisors rejects all discipline against the employee, the employee shall be exonerated and reinstated to his/ her position without loss of pay or benefits. The decision of the Board of Supervisors shall be final subject to review by the Superior Court pursuant to the provisions of Section 1094.5 of the Code of Civil Procedure.
- 12.21. **Negotiated Settlement:** At any point in the proceedings the Human Resources Manager and the employee and his/her representatives, if any, may negotiate, compromise and/or settle any dispute concerning discipline. The employee shall be granted a reasonable amount of time to have any proposed settlement reviewed by a representative of his/her choice before agreeing to and signing the settlement. Any negotiated settlement shall be reduced to writing, and shall become a permanent part of the employee's personnel file.
- 12.22. **Negative Evaluation and Disciplinary Action:** All negative evaluations and disciplinary documents shall remain a part of the employee's personnel file. Negative evaluations shall not be used by the appointing authority in decisions to dismiss if the performance has improved or the action which merited a warning or reprimand has not reoccurred, each/both for a period of at least one (1) year. A written warning or written reprimand shall remain a part of the employees personnel file for a period of one (1) year from the date of the signed receipt. Violations resulting in suspension or demotion shall remain a part of the employees file for two (2) years from the date of the signed receipt. These time limits, however, may be decreased at the discretion of the Human Resources Manager.
- 12.23. **Termination of a Grant or Temporary Extra-Help or Limited-Term Employee:** A grant or extra-help or limited-term temporary employee may be terminated at any time without right of appeal or hearing, except as may otherwise be provided by law. In case of termination the

appointing authority shall provide the employee written notification of the reason for termination.

ARTICLE XIII
EFFECT OF MEMORANDUM OF UNDERSTANDING

It is understood and agreed that the specific provisions contained in this Memorandum of Understanding shall prevail over County practices and procedures to the extent permitted by State law, and that in the absence of specific provisions in this MOU, such practices and procedures are discretionary on the part of the County. Unless specifically waived in this Memorandum of Understanding, the County specifically reserves its right to make decisions relating to the merits, necessity or organization of any service or activity as authorized by Government Code Section 3504.

ARTICLE XIV
ARTICLE/SECTION REPLACEMENT

If any provisions of this MOU are held to be contrary to law by agreement of the parties or by a court of competent jurisdiction, those provisions will be deemed invalid, except to the extent permitted by law, but all other provisions will continue in full force and effect. In the event any Article or Section of this MOU is held contrary to law, the County and the Association agree to meet and confer within fourteen (14) days after this holding for the purpose of arriving at a mutually satisfactory and legally enforceable replacement for the Article or Section.


ARTICLE XV REOPENER

Each party shall be entitled to re-open negotiations one time per fiscal year during the term of this Agreement for the purpose of meeting and conferring on items of economic significance. Re-opening of this Agreement may also occur by mutual consent.

Mutually Recommended:
COUNTY OF DEL NORTE

DEL NORTE COUNTY SHERIFF'S
EMPLOYEES ASSOCIATION


Jay Sarina
County Administrative Officer


Daniel Schneck, President
Sheriff's Employees Association


Neal Lopez
Assistant County Administrative Officer


Jerin Gill, Vice President
Sheriff's Employees Association

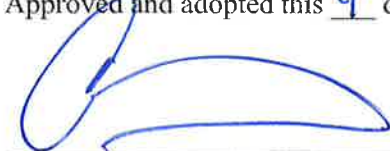

Cathy Hafterson
Human Resources/Risk Manager

12/12/17
Date



Clinton Schaad
Auditor Controller

1/10/2018
Date

Approved and adopted this 9th day of January 2018 by the Del Norte County Board of Supervisors


Chris Howard
Del Norte County Board of Supervisors

Approved as to form:


Elizabeth Cable
County Counsel


Kylie Heriford
Clerk of the Board

ATTACHMENT A

Classifications Covered by this MOU effective 10/6/2017

Job Title	Range No.	Step A	Step B	Step C	Step D	Step E
Bailiff Sergeant	51	\$2,000.38	\$2,100.42	\$2,205.42	\$2,315.70	\$2,431.48
Budget & Logistics Manager I	48	\$1,858.58	\$1,951.51	\$2,049.08	\$2,151.55	\$2,259.12
Budget & Logistics Manager II	53	\$2,100.42	\$2,205.42	\$2,315.70	\$2,431.48	\$2,553.06
Civil/Account Clerk I	30	\$1,198.05	\$1,257.96	\$1,320.85	\$1,386.91	\$1,456.24
Civil/Account Clerk II	34	\$1,320.85	\$1,386.91	\$1,456.24	\$1,529.06	\$1,605.51
Commander	58	\$2,372.08	\$2,490.68	\$2,615.21	\$2,745.98	\$2,883.28
Coroner's Assistant	36	\$1,386.91	\$1,456.24	\$1,529.06	\$1,605.51	\$1,685.78
Correctional Officer I	31	\$1,228.07	\$1,289.47	\$1,353.95	\$1,421.64	\$1,492.72
Correctional Officer II	35	\$1,353.95	\$1,421.64	\$1,492.72	\$1,567.35	\$1,645.72
Correctional Officer III	37	\$1,421.64	\$1,492.72	\$1,567.35	\$1,645.72	\$1,728.00
Correctional Officer Rec	29	\$1,169.59	\$1,228.07	\$1,289.47	\$1,353.95	\$1,421.64
Correctional Sergeant	44	\$1,685.78	\$1,770.08	\$1,858.58	\$1,951.51	\$2,049.08
Correctional Technician I	26	\$1,086.67	\$1,141.01	\$1,198.05	\$1,257.96	\$1,320.85
Correctional Technician II	29	\$1,169.59	\$1,228.07	\$1,289.47	\$1,353.95	\$1,421.64
Correctional Technician III	31	\$1,228.07	\$1,289.47	\$1,353.95	\$1,421.64	\$1,492.72
Deputy Sheriff/Coroner I	40	\$1,529.06	\$1,605.51	\$1,685.78	\$1,770.08	\$1,858.58
Deputy Sheriff/Coroner II	42	\$1,605.51	\$1,685.78	\$1,770.08	\$1,858.58	\$1,951.51
Deputy Sheriff/Coroner III	44	\$1,685.78	\$1,770.08	\$1,858.58	\$1,951.51	\$2,049.08
Deputy Sheriff/Coroner Recruit	36	\$1,386.91	\$1,456.24	\$1,529.06	\$1,605.51	\$1,685.78
Detective Sergeant	52	\$2,049.08	\$2,151.55	\$2,259.12	\$2,372.08	\$2,490.68
Dispatcher I	32	\$1,257.96	\$1,320.85	\$1,386.91	\$1,456.24	\$1,529.06
Dispatcher II	34	\$1,320.85	\$1,386.91	\$1,456.24	\$1,529.06	\$1,605.51
Dispatcher III	36	\$1,386.91	\$1,456.24	\$1,529.06	\$1,605.51	\$1,685.78
Property Clerk I	26	\$1,086.67	\$1,141.01	\$1,198.05	\$1,257.96	\$1,320.85
Property Clerk II	29	\$1,169.59	\$1,228.07	\$1,289.47	\$1,353.95	\$1,421.64
Property Clerk III	31	\$1,228.07	\$1,289.47	\$1,353.95	\$1,421.64	\$1,492.72
Senior Dispatcher	38	\$1,456.24	\$1,529.06	\$1,605.51	\$1,685.78	\$1,770.08
Sergeant	51	\$2,000.38	\$2,100.42	\$2,205.42	\$2,315.70	\$2,431.48
Sheriff's Secretary I	32	\$1,257.96	\$1,320.85	\$1,386.91	\$1,456.24	\$1,529.06
Sheriff's Secretary II	34	\$1,320.85	\$1,386.91	\$1,456.24	\$1,529.06	\$1,605.51

ATTACHMENT A

Classifications Covered by this MOU effective 7/13/2018

Job Title	Range No.	Step A	Step B	Step C	Step D	Step E
Bailiff Sergeant	51	\$2,135.41	\$2,242.20	\$2,354.29	\$2,472.01	\$2,595.60
Budget & Logistics Manager I	48	\$1,946.86	\$2,044.21	\$2,146.41	\$2,253.75	\$2,366.43
Budget & Logistics Manager II	53	\$2,200.19	\$2,310.18	\$2,425.70	\$2,546.98	\$2,674.33
Civil/Account Clerk I	30	\$1,254.96	\$1,317.71	\$1,383.59	\$1,452.79	\$1,525.41
Civil/Account Clerk II	34	\$1,383.59	\$1,452.79	\$1,525.41	\$1,601.69	\$1,681.77
Commander	58	\$2,532.20	\$2,658.80	\$2,791.74	\$2,931.33	\$3,077.90
Coroner's Assistant	36	\$1,452.79	\$1,525.41	\$1,601.69	\$1,681.77	\$1,765.85
Correctional Officer I	31	\$1,310.96	\$1,376.51	\$1,445.34	\$1,517.60	\$1,593.48
Correctional Officer II	35	\$1,445.34	\$1,517.60	\$1,593.48	\$1,673.15	\$1,756.81
Correctional Officer III	37	\$1,517.60	\$1,593.48	\$1,673.15	\$1,756.81	\$1,844.64
Correctional Officer Rec	29	\$1,225.15	\$1,286.40	\$1,350.72	\$1,418.26	\$1,489.17
Correctional Sergeant	44	\$1,799.57	\$1,889.56	\$1,984.03	\$2,083.24	\$2,187.39
Correctional Technician I	26	\$1,138.29	\$1,195.21	\$1,254.96	\$1,317.71	\$1,383.59
Correctional Technician II	29	\$1,225.15	\$1,286.40	\$1,350.72	\$1,418.26	\$1,489.17
Correctional Technician III	31	\$1,286.40	\$1,350.72	\$1,418.26	\$1,489.17	\$1,563.62
Deputy Sheriff/Coroner I	40	\$1,632.27	\$1,713.88	\$1,799.57	\$1,889.56	\$1,984.03
Deputy Sheriff/Coroner II	42	\$1,713.88	\$1,799.57	\$1,889.56	\$1,984.03	\$2,083.24
Deputy Sheriff/Coroner III	44	\$1,799.57	\$1,889.56	\$1,984.03	\$2,083.24	\$2,187.39
Deputy Sheriff/Coroner Recruit	36	\$1,452.79	\$1,525.41	\$1,601.69	\$1,681.77	\$1,765.85
Detective Sergeant	52	\$2,187.39	\$2,296.78	\$2,411.61	\$2,532.20	\$2,658.80
Dispatcher I	32	\$1,317.71	\$1,383.59	\$1,452.79	\$1,525.41	\$1,601.69
Dispatcher II	34	\$1,383.59	\$1,452.79	\$1,525.41	\$1,601.69	\$1,681.77
Dispatcher III	36	\$1,452.79	\$1,525.41	\$1,601.69	\$1,681.77	\$1,765.85
Property Clerk I	26	\$1,138.29	\$1,195.21	\$1,254.96	\$1,317.71	\$1,383.59
Property Clerk II	29	\$1,225.15	\$1,286.40	\$1,350.72	\$1,418.26	\$1,489.17
Property Clerk III	31	\$1,286.40	\$1,350.72	\$1,418.26	\$1,489.17	\$1,563.62
Senior Dispatcher	38	\$1,525.41	\$1,601.69	\$1,681.77	\$1,765.85	\$1,854.16
Sergeant	51	\$2,135.41	\$2,242.20	\$2,354.29	\$2,472.01	\$2,595.60
Sheriff's Secretary I	32	\$1,317.71	\$1,383.59	\$1,452.79	\$1,525.41	\$1,601.69
Sheriff's Secretary II	34	\$1,383.59	\$1,452.79	\$1,525.41	\$1,601.69	\$1,681.77

ATTACHMENT B

Health Care Plan Book

COUNTY OF DEL NORTE

SUMMARY PLAN DESCRIPTION OF THE MEDICAL, PRESCRIPTION & DENTAL BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE "COUNTY OF DEL NORTE GROUP HEALTH PLAN" – PLAN # 501

ORIGINAL EFFECTIVE DATE: JANUARY 1, 2007
RESTATED EFFECTIVE: JANUARY 1, 2015

Contract Administrator:
Delta Health Systems
Stockton, California

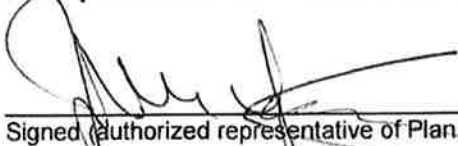
PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

**Delta Health Systems
1234 W. Oak Street
Stockton, CA 95201**

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Benefit Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator: County of Del Norte



Signed (authorized representative of Plan Sponsor)

4/8/2015

Date

THIS DOCUMENT WAS NOT PREPARED OR REVIEWED BY AN ATTORNEY AND IS NOT INTENDED AS LEGAL ADVICE.

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Legal Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes - It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content & Delivery - Notification of a Qualifying Event must be made, in writing, on a "Notification of a COBRA Qualifying Event or Social Security Disability" form. Notification must include evidence that a Qualifying Event or other event allowing extended coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

Notification of an address change must be provided on an "Address Notification Form."

Notification forms must be sent to and received by:

**Delta Health Systems
Eligibility Department
P.O. Box 1147 Stockton, CA 95201-1147**

Contact Delta Health Systems at (800) 422-6099 with any questions regarding the above procedures.

Time Requirements for Notification - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date such Qualified Beneficiary is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

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IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

This group health plan believes this plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

County of Del Norte
981 H Street, Suite 250
Crescent City, CA 95531

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when they have a question or needs help.

TYPE OF SERVICE PROVIDER

Plan Sponsor / Plan Administrator Interprets the Plan, answers eligibility questions. Provides claims forms and ID cards. Receives COBRA payments.	County of Del Norte 981 H Street, Suite 250 Crescent City, CA 95531 (707) 464-7213
Contract Administrator Handles claims and eligibility determinations. A Plan participant can also obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the Contract Administrator.	Delta Health Systems 1234 West Oak Street / P. O. Box 551 Stockton, CA 95201-0551 Phone: (209) 948-8483 or (800) 422-6099 www.deltahealthsystems.com
Utilization Management Administers the Utilization Management Program (e.g., pre-admission and review requirements).	Delta TeamCare P.O. Box 1147 Stockton, CA 95204-1147 (877) 464-1441
Network Provides a Network of providers contracted to provide services at discounted rates. If Covered Person's personal Physician is not a Network provider, application for membership can be made.	First Health
Prescription Drug Vendor Provides prior authorization for specific medications. Supplies replacement prescription cards. Processes claims for prescriptions purchased outside of the network. Transfer existing prescriptions from a different pharmacy. Reorder medication(s) previously filled by PPS.	National Medical Health Card Systems, Inc., (NMHC) 9343 Tech Center Drive, Suite 200 Sacramento, CA 95826-2592 (800) 777-0074 – Customer Care Postal Prescription Services (PPS) P.O. Box 2718 Portland, OR 97208-2718 (800) 552-6694 www.ppsrx.com

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The name and phone number of the organization is shown on the Employee's coverage identification card.

Compliance Procedures - The procedures outlined below should be followed to avoid a possible penalty:

Inpatient Admission - Except as noted, prior to any non-emergency admission to a Hospital or Skilled Nursing Facility (including admissions for mental health and substance abuse), the Covered Person or someone acting on their behalf must contact the Utilization Management Organization for pre-service review and authorization.

For an emergency admission, the Utilization Management Organization must be contacted within 72 hours after admission. An emergency admission is one that involves the sudden onset of severe medical symptoms that: (1) could not have been reasonably anticipated, (2) requires immediate medical treatment, or (3) can be considered life-threatening.

If, in the opinion of the patient's Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the Utilization Management Organization no later than the last authorized day.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Durable Medical Equipment - Prior to the purchase or rental of durable medical equipment where the cost will exceed \$500, the Utilization Management Organization should be contacted for pre-service review and authorization.

Home Health Care / Home Hospice Care - Prior to beginning a program of home health care or home Hospice care, the Utilization Management Organization must be contacted for pre-service review and authorization.

Nursing Services - Pre-service review is required prior to receiving services of a registered nurse (RN).

Outpatient Surgery - Prior to any elective (non-emergency) surgery performed in the Outpatient department of a Hospital or an Ambulatory Surgical Facility, the Utilization Management Organization must be contacted for pre-service review and authorization.

NOTE: Pre-Admission review is not required for retirees or Dependents of retirees who are age 65 or older.

Penalty for Non-Compliance -If the above pre-service review requirements are not completed for an Inpatient admission, Home Health Care / Home Hospice Care, Nursing Services or an Outpatient Surgery, then benefits otherwise payable will be reduced by 50%, to a maximum benefit reduction of \$500.

No penalty will be applied for failure to pre-authorize Durable Medical Equipment.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed **ONLY** to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

MEDICAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of their choice (Non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider their out-of-pocket costs may be reduced because they will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible - see the Schedule of Medical Benefits, below.

The Plan Sponsor will automatically provide a Plan participant with information about how they can access a directory of Network providers. This information will be provided without charge. The directory will be available either in hard copy as a separate document, or in electronic format. Since certain covered services and supplies may not be available through the Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included.

Although there may be circumstances when a Network provider cannot be used, Non-Network provider services will be covered at the Non-Network benefit levels. However, if a Covered Person is admitted to a Non-Network Hospital on an emergency basis for a condition which requires immediate treatment to prevent loss of life, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that they could be transferred to Network provider care. Thereafter, the Covered Person must be transferred to Network provider care (transfer will be at the Plan's expense) or Non-Network benefit levels will commence.

BALANCE-BILLING

In the event that a claim submitted by a Network or non-Network provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over non-Network providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Network provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network provider.

The Covered Person is responsible for payment of co-insurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Benefit Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Benefit Document.

SCHEDULE OF MEDICAL BENEFITS

MAXIMUM LIFETIME BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLES	
Individual Deductible	\$400
Family Maximum Deductible	\$700
<p><u>Individual Deductible</u> - The Individual Deductible is an amount a Covered Person must contribute toward payment of eligible medical expenses. The Deductible usually applies before the Plan begins to provide benefits.</p> <p><u>Family Maximum Deductible</u> - If \$700 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and their covered Dependents.</p> <p><u>Deductible Carry-Over</u> - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year. Nevertheless, the Individual Deductible amount must be satisfied with expenses incurred within a 12-month period.</p> <p><u>Common Accident Provision</u> - If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. The Individual Deductible requirement for each member of the family who is involved in the accident will be credited with a pro-rata share of the 1 Individual Deductible amount applied to accident-related expenses.</p>	

OUT-OF-POCKET MAXIMUMS	Network	Non-Network
Individual Out-of-Pocket Maximum	\$2,000	\$4,000
Family Out-of-Pocket Maximum	\$4,000	\$7,000
<p>Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than \$4,000 (or \$2,000 for Network services and supplies) toward their share of Eligible Expenses that are not paid by the Plan. Once they have paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p>Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and their Dependents) will not be required to pay more than \$7,000 (or \$2,000 for Network services and supplies) toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Network Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> amounts applied or paid to satisfy any Deductible or Co-Pay requirements; expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program. 		

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Chiropractic Care	80%	60%
Limited to 15 visits per Calendar Year.		
Durable Medical Equipment	80%	60%
Home Health Care / Home Hospice Care	80%	60%
Limited to 100 visits per Calendar Year. Each visit by a home care provider will count as 1 visit.		
Hospital Services		
Inpatient Care (non-newborn)	80%	60%
Newborn Nursery Care, Routine	100%	60%
Emergency Room Care, per use – see NOTE	\$100 Co-Pay, then 80%	\$100 Co-Pay, then 60%
Other Outpatient Services & Supplies	80%	60%
Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see Definitions) or the actual charge for Medically Necessary use of an Intensive Care Unit.		
NOTE: The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.		
Learning Impairment	80%	60%
A "benefit period" is a 6-month period that starts on the day a covered child first incurs a treatment charge. The charge must not belong to a prior benefit period. If a child is in a benefit period when their coverage ends, the provisions of this benefit will still apply, but only until the end of the benefit period.		
A charge is deemed incurred when the treatment is performed or supplies are purchased. If a charge is made for a total treatment program, the charge will be prorated to determine a daily charge.		
Mental Health Care – Inpatient & Outpatient	80%	60%
Physician Services	80%	60%
Pre-Admission Testing	(See "Diagnostic Lab & X-Ray, Outpatient")	
Prescription Drugs, Outpatient		
<u>Retail Feature</u>		
Generic Drug	\$15 Co-Pay†	
Formulary Brand-Name Drug	\$35 Co-Pay†	
Non- Formulary Brand-Name Drug	\$55 Co-Pay†	
<u>Mail-Order Option</u>		
Generic Drug	\$20 Co-Pay†	
Formulary Brand-Name Drug	\$70 Co-Pay†	
Non- Formulary Brand-Name Drug	\$110 Co-Pay†	

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
<p>Prescription drug coverage involves a program through an independent vendor. To use the retail feature, a Covered Person takes their drug ID card to a participating pharmacy to fill their prescription order. A retail prescription can be purchased in up to a 30-day supply for the Co-Pays shown.</p> <p>A mail-order option is included for maintenance (longer-term) drugs. Mail-order drugs are available in up to a 90-day supply for the Co-Pays shown.</p> <p>If a Covered Person fills a prescription at a non-participating pharmacy, they must pay the full charge of the prescription and submit a claim form to the vendor for reimbursement.</p> <p>A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor.</p> <p>NOTE: The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's personnel office or the office of the Plan Sponsor.</p>		
<p>Preventive Care</p> <p>100%†</p> <p>80%†</p> <p>Preventive care includes:</p> <p>periodic well child check-ups;</p> <p>immunizations & health screenings;</p> <p>1 routine Pap smear per 12-month period, or as recommended by a Physician;</p> <p>1 routine mammogram per 12-month period, or as recommended by a Physician;</p> <p>1 routine prostate screening per 12-month period, or as recommended by a Physician;</p> <p>an annual flu shot;</p> <p>Colonoscopy is covered under the preventive benefit and is payable at 80% for in network and 60% out of network once the member deductible is met.</p>		
<p>Skilled Nursing Facility</p> <p>First 20 Days of Confinement, per Calendar Year</p> <p>Thereafter</p> <p>Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 120 days per Calendar Year.</p>	<p>90%</p> <p>80%</p>	<p>70%</p> <p>60%</p>
<p>Smoking Cessation</p> <p>Limited to 1 treatment per Lifetime.</p>	<p>50%</p>	<p>50%</p>
<p>Speech Therapy</p>	<p>80%</p>	<p>60%</p>
<p>Substance Abuse Care— Inpatient & Outpatient</p>	<p>80%</p>	<p>60%</p>
<p>Weight Control (Bariatric Surgery)</p>	<p>Benefits not to exceed \$25,000.00</p>	

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Also, benefits for bariatric surgery are available only after an individual has been enrolled in the Plan for at least three (3) years.		
All Other Eligible Medical Expenses	80%	60%

† Calendar Year Deductible does not apply.

ABOUT THE SCHEDULE...

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

A "Co-Pay" is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

THIS IS A SUMMARY ONLY. SEE THE ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g., application of Deductible and Co-Pay requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and that are incurred by a Covered Person - subject to the **Definitions, Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

Alcoholism - see "Substance Abuse Care"

Allergy Testing & Treatment - Allergy testing and treatment, including allergy injections.

Ambulance - Medically Necessary ambulance service, including the base charge, mileage and supplies, to transport a Covered Person to and from the nearest Hospital where treatment can be given.

Transport of a Covered Person to the nearest Hospital where special treatment can be given when such treatment is not locally available. Eligible Expense includes charges made by an ambulance service, railroad or regularly scheduled airline.

NOTE: Transportation is not covered when provided outside of the United States or Canada, or when undertaken to secure the services of a Physician or group of Physicians or institution of greater renown or degree of specialization.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia -Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birth Center - Services and supplies provided by a Birth Center (see **Definitions**) in connection with a covered Pregnancy.

Blood -Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Chemical Dependency - see "Substance Abuse Care"

Chemotherapy -Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic Care - Musculoskeletal manipulation and modalities (e.g. hot & cold packs) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

NOTE: Routine or maintenance treatments are not covered.

Diagnostic Lab & X-ray, Outpatient - Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis - Dialysis services and supplies, including the training of a person to assist the patient with home dialysis,

when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.

Home Health Care / Home Hospice Care – Medically Necessary services of a Home Health Care Agency or Hospice Agency, including services of registered nurses (RNs), licensed vocational nurses (LVNs), physical therapists, occupational therapists, speech therapists or medical social service workers.

Home health care or home Hospice care must be ordered by a Physician.

Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

Learning Impairment – Services and supplies, as listed below, that are provided to a covered Dependent child by a Remedial Clinic (see **Definitions**). The care must be provided in accordance with a learning impairment treatment plan. A "treatment plan" is a program, made up and carried out by a Remedial Clinic, that is intended to: (1) cure or improve any condition (whether functional or organic) which causes or contributes to a learning impairment, and (2) overcome, improve or make up for the learning impairment.

Eligible Expenses include:

- up to \$200 of expenses for an initial series of physical, neurological, mental, associative memory, lateral dominance and similar standard tests made by a Remedial Clinic to determine the nature and extent of a learning impairment and devise the treatment plan for it;

- room and board furnished by a Remedial Clinic on its own premises for a child treated on a resident basis;

- educational therapy (i.e., therapeutic training exercises and multi-sensory teaching techniques). The therapy must be meant to reduce the degree of impairment and not to teach specific subject-matter knowledge;

- periodic administration of standard achievement tests to determine the child's progress under the treatment plan.

NOTE: Eligible learning impairment expenses will not include:

- expenses which exceed Usual, Customary and Reasonable;

- expenses which the Covered Person is not legally required to pay;

- tutoring in specific subjects;

- rental of books, tools, equipment, implements, eye glasses, contact lenses, hearing aids or supplies of any kind;

- travel or sports, hobbies, camping and other activities which are mainly recreational (whether or not such travel and activities are deemed part of the treatment plan).

Medical Supplies, Disposable – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

Medicines - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Mental Health Care - Inpatient and Outpatient treatment of mental health conditions, including counseling for marital problems, family problems or behavioral problems when provided on referral by a Physician (MD).

For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence.

NOTE: A mental health condition or covered mental health care will not include:

- Inpatient or Outpatient eating disorder programs;
- learning disorders including attention deficit disorder, hyperkinetic syndrome, autism or mental retardation;
- hypnotherapy;
- sex counseling or sex therapy;
- vocational testing or training.

Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

Newborn Care - Medically Necessary services and supplies for a covered newborn who is sick or injured. See "Pregnancy Care" for well-newborn expenses.

Nursing Services, Private Duty - Private-duty nursing services of a registered nurse (RN) when ordered by a Physician.

Orthotics - Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and are required for support of an injured or deformed part of the body as a result of a congenital condition or an Accidental Injury or Sickness. NOTE: Foot orthotics are not covered.

Oxygen - see "Durable Medical Equipment"

Physical Therapy - Professional services of a licensed physical therapist when ordered by a Physician.

Physician Services - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

Pregnancy Care - Eligible Pregnancy-related expenses of a Covered Person. Eligible Expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

- pre-natal visits and routine pre-natal and post-partum care;
- expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;
- genetic testing or counseling when deemed Medically Necessary by a Physician;
- newborn Hospital services provided during the mother's confinement for delivery, but not to exceed the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother who is not a Covered Person.

Prescription Drugs -Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the **Medical Benefit Summary** for additional information.

Preventive Care - Certain preventive services that are provided in the absence of sickness or injury. See the **Medical Benefit Summary** for further information.

Prosthetics – Surgical implants, artificial limbs or eyes, post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act, and the first pair of contact lenses or glasses when required as a result of eye surgery.

Penile implants, but only for documented irreversible vascular or neuralgic disease that prevents normal male sexual function.

Radiation Therapy - Radium and radioactive isotope therapy.

Respiratory / Inhalation Therapy -Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration and to improve respiratory function.

Second (& 3rd) Surgical Opinion - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility -Inpatient care in Skilled Nursing Facility when admission to the facility is Medically Necessary.

Smoking Cessation - Examinations and prescriptions for tobacco cessation treatment (i.e., to assist a Covered Person to quit smoking).

NOTE: Group or individual counseling sessions are not covered. Smoking cessation programs are not covered.

Speech Therapy – Services of a qualified speech therapist when ordered by a Physician.

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Substance Abuse Care - Inpatient treatment of substance abuse and addiction, including detoxification services.

For Plan purposes, "substance abuse and addiction" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Transplant-Related Expenses – Services and supplies provided in connection with an organ or tissue transplant surgery. Coverage is provided for:

- a Covered Person who receives the organ or tissue (i.e., a person who is the transplant recipient);

- a Covered Person who donates an organ or tissue;

- an organ or tissue donor who is not a Covered Person, provided the transplant recipient is a Covered Person. Donor benefits will be reduced by any amounts paid or payable by the donor's own coverage, if any.

Urgent Care Facility – Eligible Medical Expenses, as defined herein, that are incurred by a Covered Person at an Urgent Care Facility.

Weight Control Surgery – The Plan will cover diagnostic, therapeutic and surgical services associated with Bariatric Surgery for individuals who have a documented, long standing history of clinically severe obesity, a history of failed medically and non-medically supervised weight loss programs and an acceptable surgical-risk status. "Long-standing clinically severe obesity" refers to a cumulative duration of 5 or more years where the individual has a Body Mass Index (BMI) of 35 or higher and currently has a BMI of 40 or higher, and/or is 100 lbs. over ideal body weight as recommended by the attending physician, and has one or more co-morbid life risk medical conditions.

A participant is eligible for one bariatric surgery procedure per lifetime with the maximum paid benefits not to exceed \$25,000.00. Eligible participants (includes dependents) must have been continuously enrolled in the Plan for a minimum of three (3) years. All applicable out of pocket and co-pay formulas applies. Generally accepted guidelines from the American Society for Bariatric Surgery only indicate surgery for those 18 years of age or older but also recommends that age 65 and older meet the stringent Medicare criteria for such surgery.

Covered services associated with these procedures will include:

History and complete examination, diagnostic laboratory tests, office visits, psychological evaluation and any other medically necessary tests or services as determined by the attending physician and/or as required by Delta Team Care for determination of medical necessity.

NOTE: Eligible Expenses do not include: Charges for after care lodging, skin modifications, or reversals.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE MEDICAL BENEFIT SUMMARY FOR THAT INFORMATION.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion - Elective abortion, unless: (1) the mother's life would be endangered if the Pregnancy were allowed to continue to term, or (2) the procedure is Medically Necessary in order to treat a Sickness or Accidental Injury.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Acupuncture / Acupressure - Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Biofeedback - Biofeedback, aversion therapy, recreational or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Complications of Non-Covered Treatment - Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered under the terms of the Plan, unless expressly stated otherwise.

Contraceptives - Medications, injections, implants, devices (e.g., IUDs or diaphragms), the fitting of devices, or any other services or supplies provided for birth control purposes.

NOTE: Contraceptives may be available through the Plan's prescription drug program. See "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**.

Cosmetic & Reconstructive Surgery, Etc. - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

Medically Necessary treatment to repair or alleviate bodily damage caused by Sickness or Accidental Injury;

coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

breast reduction surgery when Medically Necessary and after all other conventional non-surgical therapies have been exhausted;

Medically Necessary surgery for the correction of a medical condition that impairs normal body function.

Custodial & Maintenance Care - Care or confinement primarily for the purpose of meeting personal needs (e.g., bathing or walking) that could be rendered at home or by persons without professional skills or training.

Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable the patient to live outside of an institution.

Any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time, except as may be included as part of a formal Hospice care program.

NOTE: This exclusion is not intended to exclude coverage for Medically Necessary services provided at a transitional living center.

Dental & Oral Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

treatment of oral tumors; and

repair of sound natural teeth, and their dependent tissues, that are damaged in an Accidental Injury.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Dietician or Nutritional Counseling – Dietician or nutritional counseling for conditions other than diabetes.

Eating Disorder Programs – Programs to assist individuals who have an obsession with food and weight (e.g., anorexia nervosa, bulimia, etc.).

Ecological or Environmental Medicine -Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation. Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Foot Care, Routine - Routine and non-surgical foot care services and supplies including, but not limited to:

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

treatment of weak, strained, flat, unstable or unbalanced feet;

orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a covered Pregnancy.

Hair Restoration - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hearing Exams & Hearing Aids - Hearing exams, hearing aids or the fitting of hearing aids.

NOTE: This exclusion will not apply to treatment of hearing loss necessitated by an Accidental Injury, provided treatment begins within ninety (90) days of the injury and then limited to expenses incurred within twenty-four (24) months of the injury.

Holistic, Homeopathic or Naturopathic Medicine - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy - Treatment by hypnotism.

Impregnation - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Testing or Treatment - Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

Maintenance Care – see “Custodial & Maintenance Care”

Massage Therapy – Massage therapy, except when prescribed by a Covered Provider for treatment of a Sickness or Accidental Injury.

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed - Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Preventive or Routine Care - Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sex-Related Disorders - Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies except as expressly covered (see "Prosthetics" in the list of **Eligible Medical Expenses**). Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

TMJ / Jaw Joint Treatment - Treatment of temporomandibular joint dysfunction (TMJ) abnormalities caused by malocclusion, structural jaw abnormalities or any other conditions unrelated to an external traumatic episode.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (e.g., eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy, keratomoleusis or any other surgery to correct refractive defects of the eye.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following eye surgery.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

Wigs or Wig Maintenance - see "Hair Restoration"

- (See also **General Exclusions section**) -

DENTAL BENEFIT SUMMARY

PLAN MAXIMUMS		
Calendar Year Maximum Benefit (non-ortho)		\$2,500
Non-Surgical TMJ Lifetime Maximum Benefit		\$500
Orthodontia Lifetime Maximum Benefit		\$2,000
Plan benefits for each Covered Person will not exceed the maximums shown above.		
Orthodontia benefits are limited to covered Dependent children who are under age 18 and who have been continuously covered under the Plan for at least 2 years. Orthodontia benefits do not apply to the Calendar Year Maximum Benefit. The Orthodontia Lifetime Maximum Benefit applies to all periods a child is covered under the Plan.		
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE		\$25
The Individual Calendar Year Deductible is an amount that a Covered Person must contribute toward payment of eligible dental expenses. Usually, the deductible applies before the Plan begins to provide benefits.		
ELIGIBLE DENTAL EXPENSES	Covered Person Pays	Pays Plan Pays
Preventive Services	-0-	100%
Limits applicable to certain Preventive Services:		
<ul style="list-style-type: none"> • routine oral examinations and cleanings are limited to 1 exam/cleaning per 6-month period; • fluoride treatment is limited to children under age 16 and to 1 application per 6-month period; • sealants are limited to children under age 16; • a routine full-mouth X-ray series or a panoramic X-ray is limited to once per 3-year period, unless there is a demonstrated dental need for additional X-rays other than bitewings; • routine bitewing X-rays are limited to 1 set per 6-month period. 		
Basic Services	20%	80%
Scaling and root planing is limited to twice per area of the mouth per 12-month period.		
Major Services (including non-surgical TMJ treatment & Implants)	50%	50%
Orthodontia	50%	50%

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed (i.e., where the proposed course of treatment will cost more than \$200), it is recommended that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, (e.g., maximums, limitations) that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTES: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the expenses are actually incurred.

The Plan reserves the right to have a Plan participant whose dental expense is the basis for a claim, examined by a independent dentist chosen by the Plan or an entity designated by the Plan. The Plan will pay for any such independent dental exam.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies that are listed below and: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which they are licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service, on the date the service is rendered.

NOTE: Many dental conditions can be effectively treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment that is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

PREVENTIVE SERVICES

Exams & Cleanings - Routine and diagnostic oral examinations and routine cleaning and polishing of the teeth.

Consultation by a dental specialist.

Emergency treatments.

Fluoride - Topical application of stannous or sodium fluoride.

Prophylaxis - see "Exams & Cleanings"

Sealants - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration.

Space Maintainers - Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

X-rays - Dental X-rays for diagnostic purposes, as well as routine "full mouth" X-rays or a panoramic X-ray, and routine bitewing X-rays.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with extraction of impacted teeth or when Medically Necessary to perform oral surgical procedures.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Extraction - see "Oral Surgery"

Fillings, Non-Precious - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

Injections - Injection of antibiotic drugs.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

MAJOR SERVICES

Crowns - Initial placement of crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable. Replacement of a crown that is less than five (5) years old will require documented evidence of necessity by the dentist.

Implants - Implants (materials implanted into or on bone or soft tissue to support a crown or prosthetic, including services and supplies necessary for their installation), or the removal of implants.

Inlays, Onlays, Porcelain & Gold Fillings - Initial placement of an inlay, onlay, porcelain or gold filling when a tooth cannot be satisfactorily restored with a less costly filling (e.g., amalgam) restoration.

Replacement of an inlay, onlay, porcelain or gold restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable. Replacement of a restoration that is less than five (5) years old will require documented evidence of necessity by the dentist.

Prosthetics - Initial placement of a denture or bridge to replace one or more natural teeth. Any allowance made for a prosthetic includes necessary adjustments or relining within six (6) months of placement.

Addition of teeth to a partial denture or bridge to replace natural teeth.

Replacement of an existing denture or bridge if the existing denture or bridgework is at least five (5) years old and cannot be made serviceable. Replacement of a denture or bridge that is less than five (5) years old will require documented evidence of necessity by the dentist.

Relines & Adjustments - Relining or adjustment of a denture or prosthetic when necessary and performed more than six (6) months after placement.

TMJ Treatment (Non-Surgical) - Non-surgical treatment of temporomandibular joint dysfunction.

ORTHODONTIA

Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth, including:

initial consultation, models, X-rays and other diagnostic services;

initial banding or placement of orthodontic appliance(s);

periodic adjustments; and

retainers.

Orthodontia benefits will begin upon submission of proof that the orthodontia treatment program has begun. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is shown in the "Plan Maximums" in the **Dental Benefit Summary**. This maximum applies to the entire period(s) a person is covered under the Plan.

IMPORTANT: CERTAIN ELIGIBLE DENTAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE DENTAL BENEFIT SUMMARY FOR THAT INFORMATION.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances.

Customized Prosthetics – Excess charges for precision or semi-precision attachments, overdentures, denture duplication, or customized prosthetics.

Discoloration Treatment -Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Experimental & Non-Standard Procedures – Services or supplies which do not meet the standards accepted by the American Dental Association (ADA) or by the Council of Dental Therapeutics of the American Dental Association.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital Expenses – Inpatient or Outpatient Hospital expenses.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

Medical Expenses - Any dental-related services for which coverage is provided under the terms of the medical benefits of this Plan.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by someone other than:

- a dentist (DDS or DMD);

- a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or

- a Physician furnishing dental services for which they are licensed.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

- increasing the vertical dimension;

- replacing or stabilizing tooth structure lost by attrition;

- realignment of teeth;

- gnathological recording or bite registration or bite analysis;

- occlusal equilibration.

Oral Hygiene Instruction & Supplies, Etc. - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personalization or Characterization of Dentures

Photographs

Prescription Drugs - see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the Covered Person's effective date, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be extended for up to thirty (30) days for the following:

an appliance, or modification of an appliance when the impression was taken prior to the date of termination;

a crown, inlay, onlay or gold restoration when the tooth was prepared prior to the date of termination;

root canal therapy when the pulp chamber was opened prior to the date of termination.

NOTE: Extended dental benefits will not be provided for a person who is covered or eligible to become covered under another group policy or plan which provides similar benefits.

Splinting - Appliances or restorations for splinting teeth.

Temporary Restorations & Appliances - Excess charges for temporary restorations and appliances. Expenses for the permanent restoration or appliance will be the maximum Eligible Expense.

- (See also **General Exclusions** section)-

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Alcohol - Charges that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse Care as specified in this Plan, if applicable. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Criminal Activities - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation, or any complications therefrom. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Drugs in Testing Phases - Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs that are Experimental or Investigational.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Government - Charges that the Covered Person obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Illegal Drugs or Medications - That are services, supplies, care or treatment to a Covered Person for injury or sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse Care as specified in this Plan. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Incurred by Other Persons - Charges that are expenses actually incurred by other persons.

Late-Filed Claims - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Medical Necessity - Charges that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Negligence - Services that are for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or Covered Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage - Charges that are **incurred** at a time when no coverage is in force for the applicable Covered Person and/or Dependent.

Not Acceptable - Charges that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Listed Services or Supplies - Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

Nuclear Energy Release - Any injury or illness resulting from the non-therapeutic release of nuclear energy.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc. - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression).

Subrogation, Reimbursement, and/or Third Party Responsibility - Charges that are for an illness, injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

Unreasonable – Charges that are not "Reasonable;" and are required to treat illness or injuries arising from and due to a Covered Provider's error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Covered Provider whose error caused the loss(es).

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any other health plan other than This Plan, including Medicare or other governmental benefits as permitted by law.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The health benefits that are described in this Benefit Document.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. However, where This Plan is secondary to an "Other Plan" that is a Health Maintenance Organization (HMO), This Plan will coordinate only on copayments and will not assume primary status when services are obtained from non-HMO providers.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses under This Plan:

the difference in cost between a hospital's semi-private room and a private room unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms;

any amount in excess of the highest usual and customary allowance, if a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances;

any amount in excess of the lowest of the negotiated fees, if a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees,

the lesser of the amounts, if a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements) will not be considered an Allowable Expense.

Claim Determination Period - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

No COB Provision – If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A, Part B and Part D benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

NOTE: An active Employee (or spouse) age 65 or older who is eligible for Medicare and who chooses to have Medicare as their primary carrier, may not also have coverage under this Plan.

Non-Dependent vs. Dependent - The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the noncustodial parent; and then

the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment -A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. (See "Recovery of Payments" provision for additional information).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition - The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, their attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation - As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;

- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

- any policy of insurance from any insurance company or guarantor of a third party;

- worker's compensation or other liability insurance company; or

- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement - The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state

prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Beneficiary.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance - If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;

- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

- any policy of insurance from any insurance company or guarantor of a third party;

- worker's compensation or other liability insurance company; or

- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

Separation of Funds - Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death Claims - In the event that the Plan Beneficiary dies as a result of their injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations - It is the Plan Beneficiary's obligation:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset – If timely repayment is not made, or the Covered Person and/or their attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

Minor Status - In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation - The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at anytime without notice.

Severability - In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

To participate as an Employee in the Plan coverages that are described herein, an individual must be in permanent full-time or part-time active employment for the Employer, performing all customary duties of their occupation at their usual place of employment (or at a location to which the business of the Employer requires the Employee to travel) and regularly scheduled to work at least 35 hours per week as a full-time Employee, or at least 15 hours per week as a part-time Employee.

See "Extension of Coverage for Retirees" in the **Extensions of Coverage** section for retiree coverage information.

An Employee will be deemed in "active employment" on each day the employee is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided they were actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which the employee is absent from work during an approved FMLA leave or solely due to their own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on their first scheduled workday, the employee will not be considered as having commenced active employment.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees

An Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first day of the month following 180 days of active employment in an eligible status.

If an Employee fails to enroll within thirty (30) days after completion of the waiting period, their coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents

Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a legally married spouse. A "spouse" will mean a person of the opposite sex (i.e., not the same sex as the Employee). "Legally married" means a legal union (as defined by the Employee's state of residence) between one man and one woman as husband and wife;

a child up to age 26. Child shall mean:

- a natural child;
- a stepchild;
- a child who is adopted by the Employee or placed with the Employee for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;
- notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements;

NOTES: An eligible Dependent does not include:

- any person whose primary employer offers health insurance coverage;
- a spouse following legal separation or a final decree of dissolution of marriage or divorce;
- any person who is on active duty in a military service, to the extent permitted by law;

a foster child;

any person who is eligible to be covered as an Employee;

any person who is covered as a Dependent of another Employee.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty (30) days of their eligibility date. See the "Special Enrollment Rights" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment/Re-Enrollment" provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Newborn & Adoptive Children - Limited Automatic 31-Day Benefit Period

An Employee's newborn child will be eligible for benefits for Eligible Expenses that are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. The child will be covered after the 31-day benefit period only if the child is enrolled within thirty (30) days of birth – see "Entitlement Due to Acquiring New Dependent(s)" in the **Special Enrollment Rights**.

The 31-day benefit period also applies to child who adopted by or placed with an Employee for adoption. The 31 day period begins on the date the child is placed in the physical custody of the Employee.

NOTE: During the limited 31-day benefit period, a newborn or adoptive child is not a Covered Person. Any extended coverage periods or coverage continuation options that are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within the 30-day enrollment period.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

The individual was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to them. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of

eligibility, even if the plan continues to provide coverage to other employees;

- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and

the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty (30) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the first day of the first calendar month after the Qualifying Event and completed application;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty (30) days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment allowances of the Plan.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be qualified. A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Entitlement Due to The Children's Health Insurance Program Reauthorization Act of 2009 - Employees and Dependents who are or become eligible under the State Children's Health Insurance Program (SCHIP) or Medicaid and then lose such eligibility, may enroll in the Plan (if they are otherwise eligible) within sixty (60) days of the date the Employee (or a Dependent) loses eligibility for the Medicaid or SCHIP program or within sixty (60) days of becoming eligible for premium assistance under Medicaid or SCHIP. This "special enrollment right" exists even though the timing may fall outside of a Plan's open enrollment period and the Employee previously refused Plan coverage. This enrollment allowance also applies to those who lose SCHIP or Medicaid coverage and then want to enroll in the Employer Plan.

Premium Assistance: The State may either (1) reimburse the Employer directly for the cost differential to add family coverage (to add previously uncovered children to the Plan), or (2) require covered beneficiaries to pay the full family coverage cost and reimburse the Employee. However, the Employer/Plan Sponsor can opt out of the first option, and

require the full cost of coverage from the covered Employee. To qualify, residents and their Dependent(s) must be eligible for Plan coverage in which the Employer contributes at least 40% toward the coverage cost.

Open Enrollment

If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Plan coverage will be effective on the first of the month following the end of the Open Enrollment period.

Reinstatement / Rehire

If an Employee returns to active employment and eligible status immediately following an approved leave of absence taken in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) and during the leave Employee discontinues paying their share of the cost of coverage, then the Employee may have coverage reinstated as if there had been no lapse (for the Employee and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before their family or medical leave expires and the Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. See "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of their eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

Restatement / Replacement of Benefits

This Benefit Document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. The health coverage(s) described herein are an immediate restatement or replacement of such prior benefits. Except to the extent that benefits are expressly modified, any deductibles satisfied or benefits paid with respect to covered persons under the prior benefits will be deemed to be Deductibles satisfied or benefits paid under the Benefit Document for a person who is eligible as an active enrollee or a COBRA enrollee under the Benefit Document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered under this Benefit Document.

TERMINATION OF COVERAGE

Employee Coverage Termination

Except as noted, an Employee's coverage will terminate upon the earliest of the following:

termination of the Plan or Plan benefits as described herein;

termination of participation in the Plan by the Employee;

at the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

the date the Employee dies.

NOTE: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent Coverage Termination

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

termination of the Plan or these Plan benefits or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

on the date the Employee requests that Dependent coverage be terminated or at the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

- (See **COBRA Continuation Coverage**) -

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extension of Coverage for Handicapped Dependent Children

If an already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and:

- such condition commenced on or before the child attained the age that would otherwise terminate their eligibility;
- the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and
- such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of them having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as they remain in such condition, and otherwise conforms to the definition of "Dependent."

The Employee should have a Physician submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days prior to the child's attainment of the limiting age.

Extended benefits will be continued under the terms of this provision until the earliest of: (1) the date the child ceases to be eligible for reasons other than age, (2) the date the child ceases to be incapacitated, or (3) on the 61st day after the Plan requests additional proof of the child's incapacity and Employee fails to furnish such proof.

Extensions of Coverage During Absence From Work

If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., the employee is absent due to an approved leave or a temporary layoff), the employee may be permitted to continue health care coverages for themselves and their Dependents though they could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of the Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if they: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child;
- the placement of a child with the Employee for adoption or foster care;
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition;
- Employee's own serious health condition that makes the Employee unable to perform the functions of their job; or

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of their FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious injury or illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible employee takes FMLA Leave to care for the covered veteran. A "serious illness or injury" shall mean an illness or injury incurred in the line of duty that may render the service member medically unfit to perform their military duties. A serious injury or illness for a current service member includes an injury or illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious injury or illness for a covered veteran means an injury or illness that was incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of their military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of their military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage is the lesser of:

18 months (or 24 months for elections made on or after December 10, 2004); or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Extension of Coverage for Retirees

If an Employee retires from active service from the Employer and has:

twenty-five (25) or more years of service (Sheriff's department retirees with twenty (20) or more years of service) for the Employer will be have extended coverage hereunder at no cost (for retiree only);

is under age sixty-five (65):

then, within thirty-one (31) days of the date of the employees retirement, the employee may elect to continue Plan coverage without interruption for themselves and their eligible Dependents (see NOTES below). Later election of this extension will not be permitted.

Except as noted, the retiree will be required to contribute to the Plan at rates determined by the Plan Sponsor. Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants.

NOTES: Only those individuals who were covered under the Plan on the day immediately prior to the Employee's retirement will be eligible for continued Plan coverage under the terms of this provision.

Retirees over age sixty-five (65) have the option of choosing medical and dental coverage or dental only coverage. There is no option for medical only coverage.

Retirees age 65 and over must enroll in Medicare to receive supplemental benefits.

Extension of Coverage for Survivors

If an Employee dies while covered under the Plan, any Dependents covered at the time of the Employee's death will have continued medical benefits hereunder and will not be required to pay the cost of such coverage. However, medical coverage for any such Dependent will terminate on the earlier of:

the 2-year anniversary of the Employee's death;

the date the Dependent spouse remarries;

the date the Dependent ceases to be an eligible Dependent as defined;

the date the Plan ends or is changed to end Dependent coverage for the Employee's class; or

the date the Dependent becomes covered under any other group policy or plan or under an individual policy of medical care coverage offered under any conversion privilege provision. Dependents of a retiree may continue medical coverage beyond the 2-year anniversary of the retiree's death with contribution payments at the retiree status.

- (See **COBRA Continuation Coverage**) -

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If an Employee or Dependent is Totally Disabled on the date their coverage terminates, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

upon termination of the Total Disability; one (1) year following the date coverage terminated;

upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition; upon termination of the Plan.

For an Employee, "Total Disability" or "Totally Disabled" means the Employee can perform no duty of their occupation.

For a Dependent, it means the dependent is so disabled that he can engage in none of their usual activities. A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

- (See **COBRA Continuation Coverage**) -

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or their authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

- 1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery. A Pre-Service Claim determination is not a guarantee of Plan benefits. Plan benefits are subject to review of a claim after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

- 2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within ninety (90) days after the date of service or treatment has been rendered or as soon as is reasonably possible, and except in the absence of legal capacity of the Claimant, not later than one (1) year after the end of the ninety (90) day period.

A Post-Service Claim should be submitted to:

**Delta Health Systems
1234 W. Oak Street / P. O. Box 551
Stockton, CA 95201-0551**

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign their right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action they may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or their beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond).

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Urgent Claim - defined below</p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p> <p>An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.</p> <p>Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.</p>	<p>Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.</p> <p>Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.</p> <p>See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of claimant's appeal.</p>
"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Concurrent Care Claim - defined below</p> <p>Plan Wants to Reduce or Terminate Already Approved Care</p>	<p>Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.</p>

Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.
A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	
Non-Urgent Claim	
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives <u>Completing</u> Information	Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial <u>Complete</u> Claim Request	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where plan requires 2 mandatory levels of appeal, within 15 days for each appeal).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.	
"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives <u>Completing</u> Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.

Claimant Makes Initial <u>Complete</u> Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.</p>	

Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial. The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims.

APPEAL PROCEDURES

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal their claim, in writing, to a new decision-maker and the claimant may submit new information (e.g., comments, documents and records) in support of their appeal. A Claimant may not take legal action on a denied claim until the member has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to their appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, the Claimant will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to their claim for benefits.

NOTE: The Plan will not require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both will be completed within the time frame applicable to one (1) level.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the decision; reference to the pertinent Plan provisions on which the decision is based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- identification of any medical or vocational experts whose advice was obtained in connection with the claim denial;
- identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;
- a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Covered Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Covered Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Covered Provider or other person or entity to enforce the provisions of this section, then that Claimant, Covered Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Covered Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's **Third Party Recovery, Subrogation and Reimbursement provisions**; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Covered Provider, due to a claim being made in error, a claim being fraudulent on the part of the Covered Provider, and/or the claim that is the result of the Covered Provider's misstatement, said Covered Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Allowable Expenses - Allowable Expenses shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Ambulatory Surgical Center - Any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

- does not provide services or other accommodations for patients to stay overnight.

Benefit Document - A document that describes one (1) or more benefits of the Plan. This document serves as the Plan's Benefit Document.

Birthing Center - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients; has organized facilities for birth services on its premises;

- provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

- has 24-hour-a-day registered nursing services; maintains daily clinical records.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Clean Claim - A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Covered Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Covered Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other

times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

Convalescent Hospital - see "Skilled Nursing Facility"

Covered Expense(s) – Covered Expense(s) means a Usual and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - An individual who is:

licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of their license; or
in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Dietician
Enterostomal therapist
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)*
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Marriage Family and Child Counselor (MFCC)*
Nurse Practitioner Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Physician Assistant (PA)
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatrist (MD)
Registered Nurse (RN)
Respiratory Therapist
Speech Pathologist

* Coverage is subject to referral by an MD.

A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered by the Plan:

any practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license;

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, clinics;

licensed Outpatient mental health facilities;

freestanding public health facilities;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating themselves or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for their services.

Dependent - see **Eligibility and Effective Dates** section **Eligible Expense(s)** - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

Emergency - see "Medical Emergency"

Employee - see **Eligibility and Effective Dates** section **Employer(s)** - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Experimental and/or Investigational - Experimental and/or Investigational ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;

2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a. Maximum tolerated dose;
 - b. Toxicity;
 - c. Safety;
 - d. Efficacy; and
 - e. Efficacy as compared with the standard means of treatment or Diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a. Maximum tolerated dose;
 - b. Toxicity;
 - c. Safety;
 - d. Efficacy; and
 - e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Fiduciary - Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Home Health Care Agency - An agency or organization that:

is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to

provide skilled nursing services and other therapeutic services; has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

provides for full-time supervision of its services by a Physician or by a registered nurse;

maintains a complete medical record on each patient;

has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or Hospice Agency -An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital - An institution that is:

licensed as an acute care facility by the proper authority of the state in which it is located; or

recognized as a hospital by the Joint Commission on the Accreditation of Hospitals (JCAH); or

a state licensed and JCAH-recognized mental health or psychiatric facility or an alcoholic or drug treatment facility, provided that any such facility is providing a treatment program for these specific diagnosed conditions and is operating within the scope of its license.

NOTE: A Hospital does not include any institution, or part thereof, that is used primarily as a convalescent home, rest
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home, home for the aged, nursing home, custodial care facility, training center, residential care facility or halfway house.

Incurred - A Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Skilled Nursing Facility) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Lifetime - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

Maximum Amount or Maximum Allowable Charge - Maximum Amount and/or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a Covered Provider; or
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Emergency - An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and

it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by

government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Physician - A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person themselves or their relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments. (See "Benefit Document" definition for additional information).

Plan Sponsor - The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Prior to Effective Date or After Termination Date - Prior to Effective Date or After Termination Date are dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Reasonable - "Reasonable" and/or "Reasonableness" shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Covered Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Covered Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Covered Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Remedial Clinic - A legally authorized institution (not owned or run by a national or state government) used mainly as a facility for education or training through educational therapy. It must: (1) be supervised 24-hours-a-day by a Doctor of Medicine (MD) or a registered nurse (RN), (2) have the services of an MD available at all times, and (3) be staffed with a legally qualified psychiatrist or psychologist and physical and educational therapists as may be needed to make up and carry out treatment plans.

Semi-Private Room Charge - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Bodily illness or disease (other than mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;

- is under the full-time supervision of a Physician or a registered nurse;

- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

- has established methods and procedures for the dispensing and administering of drugs;

- has an effective utilization review plan;

- is approved and licensed by Medicare;

- has a written transfer agreement in effect with one or more Hospitals; and

- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Urgent Care Facility - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

Usual and Customary - "Usual and Customary" (U&C) shall mean Eligible Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Covered Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Covered Provider for providing the services, the prevailing range of fees charged in the same "area" by Covered Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Covered Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with
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generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Covered Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Usual, Customary and Reasonable (UCR) - A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate.

GENERAL PLAN INFORMATION

Name of Plan:	County of Del Norte Group Health Plan
Plan Sponsor / Plan Administrator:	County of Del Norte
Address:	981 H Street, Suite 250 Crescent City, CA 95531 (707) 464-7213
Business Phone Number:	
Participating Employer(s):	County of Del Norte
Plan Sponsor ID Number (EIN):	94-2254126
Plan Number:	501
Group Plan Designation Number:	550
Plan Year:	December 1 through November 30
Named Fiduciary:	County of Del Norte
Address:	981 H Street, Suite 250 Crescent City, CA 95531
(See also definition of "Fiduciary")	
Designated Legal Agent:	County of Del Norte
Address:	981 H Street, Suite 250 Crescent City, CA 95531
(Legal process may be served upon the Plan Sponsor or a Fiduciary)	
Plan Benefits Described Herein:	Self-Funded Medical and Prescription Drug Benefits
Type of Administration:	Contract Administration – see "Administrative Provisions" for additional information
Applicable Collective Bargaining Agreement(s):	None
Contract Administrator:	Delta Health Systems
Address:	1234 W. Oak Street Stockton, CA 95201 (209) 474-5587 or (800) 291-0726
Phone:	

FUNDING - SOURCES AND USES

Employee & Employer Obligations

Plan benefits described herein are paid from the general assets of the Plan Sponsor. Any contributions to be paid by active Employees will be determined by the Plan Sponsor.

See the **COBRA Continuation Coverage** section for more information.

Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner that is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of)

The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- reduce, modify or terminate retiree health care benefits under the Plan, if any;

- alter or postpone the method of payment of any benefit;

- amend any provision of these administrative provisions;

- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which the employee has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of supervisors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Applicable Law - Federal and State of California (see "Type of Plan" subsection below for additional information)

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies

In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which the Employee can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Benefit Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums

or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay their share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

A Summary of Material Modifications reports changes in the information provided within the Plan. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.

Material Reduction

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material reductions" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Examples include reductions in benefits or increases in deductibles or copayments.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, their eligibility, benefits or both, will be adjusted to reflect their true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation. (See also "Termination of Fraud" section below).

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that they (and their family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Not a Contract

This Benefit Document and any amendments constitute the terms and provisions of coverage under this Plan. The Benefit Document is not to be construed as a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Benefit Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of their Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of their Dependents.

Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Statements

All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact,

commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, the individual knew or should have known, contained false or fraudulent elements under state or federal law.

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact. It is a Covered Person's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Covered Person is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Covered Person and their entire Family Unit of which the Covered Person is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a 30 day notice period as described under The Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan. (See also "Misstatement / Misrepresentation" above).

Type of Plan

This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following requirements of Title XXVII of the Public Health Service (PHS) Act: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws. Your rights as a Covered Person in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of the retired Employees Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay their portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that their Medicare coverage is in effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits the Employee to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, the former Qualified Beneficiary does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes their waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to their deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- the cost previously charged was less than the maximum permitted by law;

- the increase is due to a rate increase at Plan renewal;

- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

- the Qualified Beneficiary changes their coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

Maximum Coverage Periods -The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee, themselves, experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in their family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension themselves.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that their Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

ADOPTION OF THE DOCUMENT

Adoption

The Plan Sponsor hereby adopts this document on the date shown below.

This document replaces any and all prior statements of the Plan benefits that are described herein and in that respect this document is adopted as the Benefit Document. This Benefit Document represents both the Plan Document and the Summary Plan Description. This Benefit Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers

Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Restatement / Replacement of Benefits

This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2014.

County of Del Norte

By:

Title:

By:

Title:

WITNESS:

AMENDMENT #16
TO THE 2015 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR
COUNTY OF DEL NORTE

Effective June 1, 2015 the above-referenced Plan Document of the **County of Del Norte's Medical Plan** is amended as follows:

- "Domestic Partner"
- "Domestic Partner" refers to an individual who is a member of a domestic partnership consisting of two partners each of whom: (i) is at least eighteen (18) years of age or older; (ii) resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time; (iii) is not related to the other partner by adoption or blood; (iv) is not married to anybody else; (v) is the sole Domestic Partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six (6) months; (vi) agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and (vii) is able to demonstrate financial interdependence by submission of proof of three (3) or more of the following documents:
 1. A joint mortgage or lease;
 2. A designation of one of the partners as beneficiary in the other partner's will;
 3. A durable property and health care powers of attorney;
 4. A joint title to an automobile, or joint bank account or credit account; or
 5. Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

All other sections of the Plan remain unchanged.

NOTICE TO PLAN PARTICIPANT: REVIEW THIS AMENDMENT CAREFULLY AND THEN INSERT IT INTO YOUR BENEFIT BOOKLET. THIS AMENDMENT REFLECTS CHANGE(S) TO YOUR SUMMARY PLAN DESCRIPTION AND MAY INCLUDE MATERIAL MODIFICATIONS (REDUCTIONS) IN PLAN BENEFITS.

This amendment #16 is accepted by:



Signature of Authorized Representative

6/24/15

Date

COPY

AMENDMENT #1

TO THE RESTATED 2015 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

COUNTY OF DEL NORTE

Effective July 22, 2016, the above-referenced Plan Document of the **County of Del Norte** is amended as follows:

GENERAL PLAN INFORMATION

Plan is amended to change the eligibility waiting period from "An Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first day of the month following 180 days of active employment in an eligible status." to:

Eligibility for Insurance Benefits: Employees entitled to health benefits shall be eligible for coverage following completion of sixty (60) days of active employment in an eligible status.

All other sections of the Plan remain unchanged.

NOTICE TO PLAN PARTICIPANT: REVIEW THIS AMENDMENT CAREFULLY AND THEN INSERT IT INTO YOUR BENEFIT BOOKLET. THIS AMENDMENT REFLECTS CHANGE(S) TO YOUR SUMMARY PLAN DESCRIPTION AND MAY INCLUDE MATERIAL MODIFICATIONS (REDUCTIONS) IN PLAN BENEFITS.

This amendment is accepted by:



Signature of Authorized Representative

8/15/2016

Date

ATTACHMENT C

Health Care Premium Schedule

Employee Rate Schedule

Biweekly Rate Employee:	5% of Gross*
Employee + 1*	\$ 99.18
Employee + 2*	\$152.37
Employee + 3*	\$159.00
Employee + 4 or more*	\$165.62

Cobra Rate Schedule Monthly Rate

Single	\$ 524.99
Single + 1	\$1,018.49
Single + 2 or more	\$1,532.99

Retiree Full Plan Rate Schedule

Retiree Age Under 65 Monthly Rate

10 to 15 years Single	\$ 386.06
10 to 15 years R+1 Dep	\$ 748.89
10 to 15 years R+ 2 or more	\$1,127.20
16 to 20 years Single	\$ 257.25
16 to 20 years R+1 Dep	\$ 559.76
16 to 20 years R+ 2 or more	\$ 875.02
21 to 24 years Single	\$ 128.68
21 to 24 years R+1 Dep	\$ 343.59
21 to 24 years R+ 2 or more	\$ 458.83
25 or more years Single	\$ -
25 or more years R+1	\$ 214.91
25 or more years R+2 or more	\$ 344.50

Retiree Age 65 & Over Monthly Rate

10 to 15 years Single	\$ 225.00
10 to 15 years R+1 Dep	\$ 439.91
10 to 15 years R+ 2 or more	\$ 555.15
16 to 20 years Single	\$ 200.00
16 to 20 years R+1 Dep	\$ 414.91
16 to 20 years R+ 2 or more	\$ 530.15
21 to 24 years Single	\$ 175.00
21 to 24 years R+1 Dep	\$ 389.91
21 to 24 years R+ 2 or more	\$ 505.15
25 or more years Single	\$ 150.00
25 or more years R+1	\$ 364.91
25 or more years R+2 or more	\$ 480.15

Retiree Age 65 & Over - Dental Only Monthly Rate

10 to 15 years Single	\$ 60.00
10 to 15 years R+1 Dep	\$ 115.00
10 to 15 years R+ 2 or more	\$ 165.00
16 to 20 years Single	\$ 60.00
16 to 20 years R+1 Dep	\$ 115.00
16 to 20 years R+ 2 or more	\$ 165.00
21 to 24 years Single	\$ 60.00
21 to 24 years R+1 Dep	\$ 115.00
21 to 24 years R+ 2 or more	\$ 165.00
25 or more years Single	\$ 60.00
25 or more years R+1	\$ 115.00
25 or more years R+2 or more	\$ 165.00

